Supreme Court, U.S.
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IN THE

# Supreme Court of the United States

OCTOBER TERM, 1997

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UNUM LIFE INSURANCE COMPANY OF AMERICA,
*Petitioner,*

v.

JOHN E. WARD,
*Respondent.*

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**Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit**

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## PETITION FOR A WRIT OF CERTIORARI

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## QUESTIONS PRESENTED

1. Whether, in an opinion expressly acknowledging a circuit conflict—indeed, one affecting eight circuits—the Ninth Circuit erred in holding that a state law (the "notice-prejudice" rule) need not satisfy all three McCarran-Ferguson Act criteria for the "business of insurance" in order to be saved from preemption under ERISA.

2. Whether the Ninth Circuit—contrary to the law in nine other circuits—erred in holding that a state law survives ERISA preemption even though it conflicts not only with ERISA's requirement that fiduciaries administer all plans "in accordance with" their written terms, but also with ERISA's exclusive civil enforcement scheme by expanding the remedies beyond those expressly provided for in the Act.

3. Whether—also contrary to the law in other circuits—the Ninth Circuit erred in holding that ERISA does not preempt a state law (one incorporating agency principles) even though it conflicts not only with ERISA's regulation of initial claims filing and processing and its allocation of fiduciary responsibility, but also with the remedies provided in its exclusive civil enforcement scheme.

## PARTIES

The petitioner is UNUM Life Insurance Company of America ("UNUM"). The respondent is John E. Ward.

Pursuant to Rule 29.6 of the Rules of the Supreme Court, petitioner states that UNUM Corporation is the parent of UNUM. UNUM Corporation has two non-wholly owned subsidiaries, Boston Compania Argentina de Seguros S.A. and UNUM Delaware Company. UNUM Life Insurance Company of America has one non-wholly owned subsidiary, SP Administrator, LLC.

## TABLE OF CONTENTS


| | Page |
|---|---|
| QUESTIONS PRESENTED | i |
| PARTIES | ii |
| OPINIONS BELOW | 1 |
| JURISDICTION | 1 |
| STATUTES AND REGULATIONS INVOLVED | 1 |
| STATEMENT OF THE CASE | 2 |
| A. Factual Background | 2 |
| B. The District Court Proceeding | 4 |
| C. The Ninth Circuit's Decision | 5 |
| REASONS FOR GRANTING THE WRIT | 9 |
| I. THE NINTH CIRCUIT'S ERISA PREEMPTION DECISION CONFLICTS DIRECTLY WITH HOLDINGS IN THE THIRD, FIFTH, SEVENTH, EIGHTH, TENTH AND ELEVENTH CIRCUITS | 9 |
| II. THE NINTH CIRCUIT'S PREEMPTION DECISION CONFLICTS DIRECTLY WITH NINE OTHER CIRCUITS WHICH ENFORCE WRITTEN PLAN PROVISIONS SUCH AS NOTICE REQUIREMENTS | 11 |
| III. THE NINTH CIRCUIT'S PREEMPTION DECISION COMPLETELY DISRUPTS THE UNIFORMITY OF LAW INTENDED BY CONGRESS | 16 |
| A. Disruptions Caused By The "Notice-Prejudice" Rule | 18 |

TABLE OF CONTENTS—Continued


| | Page |
|---|---|
| B. Disruptions Caused By The *"Elfstrom"* Rule | 18 |
| IV. THE NINTH CIRCUIT'S PREEMPTION DECISION IS AN ATTEMPT TO CIRCUMVENT THIS COURT'S CONTROLLING *PILOT LIFE* DECISION | 22 |
| V. THE QUESTIONS PRESENTED BY THIS PETITION HOLD IMPORTANT IMPLICATIONS FOR ERISA PLANS THAT SHOULD BE ADDRESSED BY THIS COURT | 26 |
| CONCLUSION | 30 |
| APPENDIX | |
| Opinion of the Court of Appeals, filed February 3, 1998 | 1a |
| Order of the Court of Appeals denying Petition for Rehearing, with Suggestion for Rehearing en Banc, entered March 23, 1998 | 26a |
| Order of the District Court granting Summary Judgment, filed August 8, 1995 | 27a |
| Declaration of John A. Houser, III And Portions of Exhibits In Support of Motions for Summary Judgment, filed June 26, 1995 | 34a |
| Exhibit Portions (MacQuarrie and Ward Deposition Excerpts) to Declaration of Jeffrey P. Smith, filed June 26, 1995 | 73a |
| District Court Complaint, filed September 19, 1994 | 77a |




TABLE OF AUTHORITIES

*CASES*


| | Page |
|---|---|
| *Accardi v. Davidson*, 469 U.S. 899 (1984) | 22 |
| *Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467 (11th Cir. 1988) | 10 |
| *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987) | 13 |
| *Boggs v. Boggs*, 117 S. Ct. 1754 (1997) | 29 |
| *Boyer v. Douglas Components Corp.*, 986 F.2d 999 (6th Cir. 1993) | 14 |
| *Brazinski v. Amoco Petroleum Additives Co.*, 6 F.3d 1176 (7th Cir. 1993) | 16 |
| *Brezan v. Prudential Insurance Co. of America*, 507 F. Supp. 962 (E.D.Pa. 1981) | 28 |
| *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150 (8th Cir. 1990) | 10 |
| *Burnham v. Guardian Life Ins. Co.*, 873 F.2d 486 (1st Cir. 1989) | 14 |
| *California Div. of Labor Standards Enforcement v. Dillingham Const.*, 117 S. Ct. 832 (1997) | 20 |
| *Cefalu v. B.F. Goodrich Co.*, 871 F.2d 1290 (5th Cir. 1989) | 14 |
| *Central States, Southeast and Southwest Areas Pension Fund v. Mississippi Warehouse Corp.*, 853 F. Supp. 1053 (N.D. Ill. 1994) | 15 |
| *Christie v. K-Mart Corp. Employees Retirement Pension Plan*, 784 F. Supp. 796 (D. Kan. 1992) | 15 |
| *CIGNA Healthplan v. Louisiana*, 82 F.3d 642 (5th Cir.), *cert. denied*, 117 S.Ct. 386 (1996) | 6, 9 |
| *Cisneros v. UNUM Life Ins. Co. of America*, 134 F.3d 939 (9th Cir. 1998) | 5, 6 |
| *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54 (4th Cir. 1992) (same), *cert. denied*, 506 U.S. 1081 (1993) | 14 |
| *Curtis-Wright Corp. v. Schoonejongen*, 514 U.S. 78 (1995) | 12, 21 |
| *Davies v. Centennial Life Ins. Co.*, 128 F.3d 934 (6th Cir. 1997) | 9 |
| *Davison v. Cook*, 564 F. Supp. 225 (E.D. Va. 1983), *aff'd.* mem., 734 F.2d 10 (4th Cir. 1984) | 22 |
| *Dawes Mining Co. v. Callahan*, 246 Ga. 531 (1980) | 28 |

TABLE OF AUTHORITIES—Continued


| | Page |
|---|---|
| *DeBruyne v. Equitable Life Assurance Soc.*, 920 F.2d 457 (7th Cir. 1990) | 10 |
| *Dedeaux v. Pilot Life Ins. Co.*, 770 F.2d 1311 (5th Cir. 1985) | 8 |
| *District of Columbia v. The Greater Washington Bd. of Trade*, 506 U.S. 125 (1992) | 20 |
| *Doe v. Blue Cross & Blue Shield United*, 112 F.3d 869 (7th Cir. 1997) | 13 |
| *Edwards v. Great-West Life Assur. Co.*, 20 F.3d 748 (7th Cir. 1994) | 14 |
| *Elfstrom v. New York Life Ins., Co.*, 67 Cal.2d 503 (1967) | 5, 18, 22 |
| *First National Bank of Anson County v. Gatewood*, 303 N.C. 203 | 28 |
| *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987) | 14 |
| *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) | 6, 9 |
| *Heath v. Varity Corp.*, 71 F.3d 256 (7th Cir. 1995) | 27 |
| *Howard v. Gleason Corp.*, 910 F.2d 1154 (2d Cir. 1990) | 13 |
| *Hunt v. Hawthorne Associates, Inc.*, 119 F.3d 888 (11th Cir. 1997) | 14 |
| *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) | 16 |
| *Insurance Bd. v. Muir*, 819 F.2d 408 (3d Cir. 1987) | 10 |
| *Jass v. Prudential Healthcare Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996) | 13, 18, 20 |
| *Justice v. Bankers Trust Co., Inc.*, 607 F. Supp. 527 (D.C. Ala. 1985) | 22 |
| *Kelley v. Sears, Roebuck & Co.*, 882 F.2d 453 (10th Cir. 1989) | 10 |
| *Kennedy v. System One Holdings, Inc.*, 835 F. Supp. 947 (S.D. Tex. 1993) | 15 |
| *Kinkead v. Southwestern Bell Sick. & Acci. Corp. Disability Benefit Plan*, 111 F.3d 67 (8th Cir. 1997) | 15 |
| *Laws v. Calmat*, 852 F.2d 430 (9th Cir. 1988) | 16 |




TABLE OF AUTHORITIES—Continued


| | Page |
|---|---|
| *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985) | 16, 20 |
| *McKinsey v. Sentry Ins. Co.*, 986 F.2d 401 (10th Cir. 1993) | 22 |
| *McMahan v. New England Mut. Life Ins. Co.*, 888 F.2d 426 (6th Cir. 1989) | 10 |
| *Member Services Life Ins. Co. v. Amer. National Bank and Trust Co.*, 130 F.3d 950 (10th Cir. 1997) | 14 |
| *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993) | 11 |
| *Metropolitan Life Ins. Co. v. Henry*, 217 Ind. 33 (1940) | 28 |
| *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) | 6 |
| *Nachwalter v. Christie*, 805 F.2d 956 (11th Cir. 1986) | 14 |
| *National Conf. of Blue Cross-Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1996) | 11, 16, 20, 28 |
| *Nazay v. Miller*, 949 F.2d 1323 (3d Cir. 1991) | 13 |
| *Perkins v. Time Ins. Co.*, 898 F.2d 470 (5th Cir. 1990) | 20 |
| *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) | 6, 12, 13, 16, 17 |
| *Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126 (7th Cir. 1992) | 12, 14 |
| *Roe v. General American Life Ins. Co.*, 712 F.2d 450 (10th Cir. 1983) | 13 |
| *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) | 12, 26 |
| *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562 (11th Cir.) | 13 |
| *Tiger v. AT&T Tech. Plan for Employees' Pensions, Disability Plan*, 633 F. Supp. 532 (E.D. N.Y. 1986) | 15 |
| *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105 (5th Cir. 1993) | 7, 9, 10 |
| *Turrill v. Life Ins. Co. of North America*, 753 F.2d 1322 (5th Cir. 1985) | 8, 19 |
| *Vaca v. Sipes*, 386 U.S. 171 (1967) | 16 |

TABLE OF AUTHORITIES—Continued


| | Page |
|---|---|
| *Varsic v. United States Dist. Ct.*, 607 F.2d 245 (9th Cir. 1979) | 26 |
| *White v. Jacobs Engineering Group Long Term Disability Plan*, 896 F.2d 344 (9th Cir. 1990) | 15 |
| *Williams v. UNUM Life Ins. Co. of Am.*, 113 F.3d 1108 (9th Cir. 1997) | 10 |
| *STATUTES AND REGULATIONS* | |
| 28 U.S.C. § 1254(1) | 2 |
| ERISA § 2(a), 29 U.S.C. § 1001(a) | 29 |
| ERISA § 3(16)(A)(B), 29 U.S.C. § 1002(16)(A) | 2 |
| ERISA §§ 401-414, 29 U.S.C. §§ 1101-1114 | 12 |
| ERISA § 402(a)(2), 29 U.S.C. § 1102(a)(2) | 13 |
| ERISA § 404(a)(1)(D), 29 U.S.C. §§ 1104(a)(1)(D) | 7 |
| ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) | 7, 8, 13, 24 |
| ERISA § 503, 29 U.S.C. § 1133 | 2 |
| ERISA § 504(a), 29 U.S.C. § 1144(a) | 5, 8, 12 |
| ERISA § 504(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) | 5, 10 |
| ERISA § 504(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) | 18 |
| 29 C.F.R. § 2560.503-1(b) | 15 |
| 29 C.F.R. § 2560.503-1(c)-(d) | 25 |
| 29 C.F.R. § 2560.503-1(c)-(g) | 25 |
| 29 C.F.R. § 2560.503-1(g)(2) | 25 |
| *OTHER AUTHORITIES* | |
| 13A George J. Couch *et al.*, *Couch Cyclopedia of Insurance Law* § 49.49 at 276-77 (2d ed. 1982) | 27 |


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**Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit**

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## PETITION FOR A WRIT OF CERTIORARI

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Petitioner, UNUM Life Insurance Company of America ("UNUM"), respectfully submits that a writ of certiorari should issue to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit in this case.

## OPINIONS BELOW

The opinion of the Court of Appeals is reported at 135 F.3d 1276 (9th Cir. 1998), and is reprinted in the Appendix ("App.") at 1a to 25a. The Court of Appeals' denial of UNUM's petition for rehearing, with a suggestion for rehearing en banc, entered on March 23, 1998, is unreported. App. at 26a. The District Court's opinion granting summary judgment to UNUM (App. at 27a to 33a) is unreported.

## JURISDICTION

The Court of Appeals' order denying UNUM's petition for rehearing, with a suggestion for rehearing en banc, was entered on March 23, 1998. This petition is being timely filed within 90 days of that date. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

## STATUTES AND REGULATIONS INVOLVED

This case involves the statutes and regulations set forth at App. 99a to 108a.

## STATEMENT OF THE CASE

### A. Factual Background

In February of 1983, UNUM issued a group long-term disability insurance policy to fund an employee welfare benefit plan (the "Plan") sponsored by Management Analysis Company ("MAC"), an employer with multi-state operations. App. at 59a, 47a. Respondent John Ward worked for MAC in California, serving as its President and Chief Executive Officer ("CEO"). App. at 2a, 78a, 83a to 86a. The Plan is covered by the Employee Retirement Income Security Act ("ERISA"). App. at 2a. While the employer-sponsor served as Plan Administrator,[1] UNUM performed not only the Plan's initial claims-handling and payment functions, but also the fiduciary review procedure for denied claims required by ERISA.[2] The Plan explicitly stated that the employer serves as Plan Administrator and acts on its own behalf or as an agent for its employees, and not as UNUM's agent. App. at 44a.

A participant in the Plan since its inception in 1983, Ward concedes that he was aware of the Plan and had received from MAC in 1983 a certificate of coverage containing the Plan's summary plan description. App. at 2a. This certificate described not only the Plan's benefits and requirements for eligibility and participation, but also the procedures and deadlines Ward had to follow in submitting claims to UNUM. App. at 41a to 43a. As CEO, Ward met annually with the company's human resources division to review MAC's insurance plans, including the Plan, and five months before his resignation he attended a company-wide meeting relating to MAC's benefits at which a UNUM representative gave a summary of the Plan's benefits. App. at 32a to 33a.

Ward served as President and CEO of MAC until May 8, 1992, when he resigned upon the Board of Directors' request over financial concerns about a particular company project. App. at 27a. Ward asserts that by May of 1992, he had begun to experience a disabling condition, and that by December of that year he had received a medical diagnosis of his diabetes and alleged disability. In early 1993, he applied for and received state disability benefits, and alleges that he contacted MAC's human resources division to discuss extension of his COBRA continuation insurance. In July of 1993, he received a Social Security Determination that he was eligible for Social Security benefits, a copy of which he sent to the human resources division. App. at 28a.

Ward, however, did not submit a claim for plan benefits until April, 1994. UNUM received Ward's notice and proof of claim form on April 11, 1994, nearly two years after the onset of his claimed disability. This was UNUM's first actual notice of the claimed disability. App. at 38a.

The Plan's written notice and proof of claim provisions required a participant to submit to UNUM written notice of claim for plan benefits within 30 days of the date a disability starts, if possible, and a written proof of claim, at the latest, one year and 180 days after the onset of disability. App. at 42a to 43a. Ward's notice of claim

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[1] App. at 13a; ERISA § 3(16)(A), (B), 29 U.S.C. § 1002(16)(A), (B).

[2] App. at 39a; ERISA § 503, 29 U.S.C. § 1133.

was untimely by nearly 15 months, and his written proof of claim was submitted nearly five months after the Plan's last deadline. App. at 5a. Accordingly, no benefits were "due" under the Plan's written terms.

Ward asserted, however, that he did not know about the "availability" of the Plan until April of 1994, when he claims he discovered his certificate of coverage among papers in his safety deposit box. App. at 3a. Ward also contended that MAC should be considered the "agent" of UNUM notwithstanding that MAC was the Plan Administrator and the Plan expressly stated that MAC was not UNUM's agent; that MAC purportedly knew he was "disabled" by 1992 or 1993; and that this claimed knowledge should not only be imputed to UNUM but also free him from the Plan's written requirements of timely written notice and proof of claim to UNUM. App. at 7a to 8a.

After reviewing Ward's claim for plan benefits and supporting materials, UNUM determined that he was ineligible because he did not submit his written claim within the Plan's written time limits. UNUM notified him of its decision in April of 1994; he, in turn, requested a review. App. at 29a, 90a to 95a. In the ERISA-required fiduciary review procedure for denied claims, UNUM upheld the decision to deny plan benefits. App. at 96a to 98a.

**B. The District Court Proceeding**

On September 15, 1995, Ward filed sut against UNUM and the Plan in United States District Court for the Southern District of California to recover plan benefits under ERISA. App. at 77a to 98a. He did not assert a claim against MAC. On August 8, 1995, the District Court granted UNUM and the Plan summary judgment under ERISA. App. at 27a to 33a. The District Court held that the Plan's written proof of claim provision required that proof of claim be filed with UNUM in writing within one year and 180 days after the onset of disability, and that Ward failed to comply with this provision. Additionally,



the District Court rejected Ward's arguments that California's common-law *"Elfstrom"* rule [3] survived ERISA preemption and governed the payment of plan benefits. App. at 30a to 33a. The *"Elfstrom"* rule, if applicable, would make MAC the "agent" of UNUM, imputing to UNUM any knowledge which the employer had of Ward's disability and, also in Ward's view, requiring the payment of benefits regardless of the fact that the Plan's written proof of claim provision had been violated. Ward appealed.

**C. The Ninth Circuit's Decision**

On appeal of the summary judgment, the Ninth Circuit reversed the District Court's decision on two grounds, the *"Elfstrom"* rule and California's "notice-prejudice" rule. The Ninth Circuit's holdings on both rules warrant a plenary review.

The Ninth Circuit agreed that Ward failed to satisfy the Plan's unambiguous written proof of claim provision. It then addressed Ward's contention that the "notice-prejudice" rule would preclude UNUM—the claims review fiduciary—from upholding the claim denial unless it could establish "actual prejudice" from the failure to comply with the proof of claim provision. The Ninth Circuit held that California's common-law "notice-prejudice" rule was within the scope of ERISA preemption as a state law which "related to" an employee benefit plan. ERISA § 514(a), 29 U.S.C. § 1144(a). It held, however, that the rule was "saved" from ERISA's preemption because it was a state law regulating insurance, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), and therefore could be applied to Ward's claim for plan benefits. In so doing, the Ninth Circuit followed its earlier decision in *Cisneros v. UNUM Life Ins. Co. of America*, 134 F.3d 939 (9th Cir. 1998) (*"Cisneros"*), App. at 5a

[3] The rule takes its name from *Elfstrom v. New York Life Ins. Co.*, 67 Cal.2d 503, 505 (1967).

to 6a, a case in which a petition for writ of certiorari is being filed concurrently herewith.[4]

In *Cisneros*, the Ninth Circuit had concluded that under *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 (1985), and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-50 (1987), ERISA's "saving" clause may be applicable only if the state law clears two hurdles: a common-sense test that the law be "specifically directed" at the insurance industry, and the "saving" clause requirement that the law must "regulate insurance." 134 F.3d at 944-945. To determine whether the state law regulated insurance, the Court analyzed whether it satisfies the three McCarran-Ferguson Act criteria for the "*business of insurance.*" *Id.* at 945. Under these criteria as articulated by the Supreme Court, the state law must first have the effect of transferring or spreading the policyholder's risk of loss to the insurer, "an indispensable characteristic of insurance." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211-212 (1979). Second, the state law must be an integral part of the insurance policy relationship between insurer and insured. Third, it must be limited to entities within the insurance industry. *Metropolitan Life*, 471 U.S. at 743; *Pilot Life*, 481 U.S. at 48-50. Additionally, to avoid a conflicts-preemption bar, the state law—even if it otherwise satisfies the "saving" clause—must not conflict with one of ERISA's substantive provisions, including its exclusive civil enforcement scheme. *Pilot Life*, 481 U.S. at 51-57.

In *Cisneros*, the Ninth Circuit found that California's "notice-prejudice" rule did *not* transfer or spread the policyholder's risk of loss to the insurer, and thus failed to satisfy the first McCarran-Ferguson criterion. Finding that the rule satisfied the last two criteria, the court then held that ERISA's "saving" clause would preserve a state common-law rule even though it did *not* satisfy all three criteria. 134 F.3d at 945-946. The *Cisneros* court ex-

[4] Respondent has been provided a copy of the petition in the *Cisneros* case.



pressly *acknowledged* that its ERISA "saving" clause holding conflicted with two decisions by the Fifth Circuit, *CIGNA Healthplan v. Louisiana*, 82 F.3d 642, 650 (5th Cir.), *cert. denied*, 117 S.Ct. 386 (1996), and *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993). It stated: "We recognize that the Fifth Circuit has held that all three of the McCarran-Ferguson factors must be satisfied . . . . We . . . disagree." 134 F.3d at 946.

The *Cisneros* court also rejected UNUM's arguments, based on *Pilot Life*, 481 U.S. at 51-57, that the "notice-prejudice" rule should nevertheless be preempted under conflicts-preemption because it conflicted with a number of ERISA's key substantive provisions. UNUM pointed out that the rule would require the payment of plan benefits under circumstances where payment is barred not only by the Plan's written terms, but also by ERISA's fiduciary responsibility provisions requiring that plans must be administered "in accordance with" their written terms, and its exclusive civil enforcement scheme allowing suit for benefits only if "due" under those terms. ERISA §§ 404(a)(1)(D), 502(a)(1)(B), 29 U.S.C. §§ 1104(a)(1)(D), 1132(a)(1)(B). UNUM also pointed out that the *Cisneros* holding would result in situations where a claim would be granted or denied depending on which state's law applied. The Ninth Circuit acknoweldged a direct conflict between the "notice-prejudice" rule and ERISA, conceding that the rule caused *"a plan's written terms [to be] altered,"* caused *"complications and extra burdens" on* plan administration, and made the plan *"more difficult to administer."* Furthermore, it acknowledged that the rule *"differ[ed] markedly" in various states.* 134 F.3d at 947 (emphasis added). Nevertheless, the court rejected UNUM's argument that ERISA preempted the "notice-prejudice" rule.

In addition to adopting the "notice-prejudice" rule, the *Ward* court held that ERISA did not preempt California's

common-law "*Elfstrom*" *rule*[5] under which the employer, as administrator of a group insurance plan, is deemed the "agent" of the insurer and its knowledge is imputed to the insurer. *Ward* thus allowed two state law rules to penetrate ERISA's regulatory sphere, in contrast to *Cisneros*. Similarly to the "notice-prejudice" rule, the "*Elfstrom*" rule would require the payment of plan benefits under circumstances where payment is barred both by the Plan's written terms and ERISA's fiduciary responsibility and civil enforcement provisions. The Ninth Circuit nevertheless held that the rule did not "relate to" an ERISA plan within the meaning of ERISA's preemption clause in § 514(a). It based this extraordinary holding on *Turrill v. Life Ins. Co. of North America*, 753 F.2d 1322 (5th Cir. 1985), which *preceded* this Court's 1987 landmark decision in *Pilot Life, supra*. App. at 16a to 20a. The Ninth Circuit inferred that *Turrill*, a 1985 diversity jurisdiction case, supported a holding of no ERISA preemption because the Fifth Circuit had discussed state law agency theory without, as the Ninth Circuit put it, "even hint[ing] that state agency law is somehow preempted by ERISA." App. at 18a. This is hardly surprising, given that prior to *Pilot Life* the lower courts, including the Fifth Circuit, uniformly—but incorrectly—held that ERISA did *not* preempt such claims. *See, e.g., Dedeaux v. Pilot Life Ins. Co.*, 770 F.2d 1311 (5th Cir. 1985), decided by the same three judge panel as *Turrill, reversed by Pilot Life, supra. Pilot Life* in 1987 held that state common-law actions involving claims processing and the failure to pay benefits under an insured ERISA plan obviously "relate to" the plan because they have " 'a connection with or reference to such a plan.' " It therefore held that ERISA preempted these claims both through the preemption clause in §514(a) and through the exclusivity of its civil enforcement scheme in § 502(a). 481 U.S. at 47-48, 52-57. It was on this impliedly overruled and discredited Fifth Circuit authority that the Ninth Circuit relied in adopting state agency law in a suit for plan benefits.

[5] *Elfstrom v. New York Life Ins. Co.*, 67 Cal.2d 503, 505 (1967).



## REASONS FOR GRANTING THE WRIT

### I. THE NINTH CIRCUIT'S ERISA PREEMPTION DECISION CONFLICTS DIRECTLY WITH HOLDINGS IN THE THIRD, FIFTH, SEVENTH, EIGHTH, TENTH AND ELEVENTH CIRCUITS.

Once again, the Ninth Circuit has brought itself sharply into conflict with other Circuits on important federal issues which require unformity nationwide. The ERISA preemption decision on the "notice-prejudice" rule in *Ward* and *Cisneros* creates an acknowledged, direct conflict among holdings in the Circuits which only this Court can resolve. The Ninth Circuit's holding has engendered a similar holding in the Sixth Circuit but squarely conflicts with the holdings of the Fifth Circuit, which require a state law to satisfy *all three* of the McCarran-Ferguson Act factors for the "business of insurance" in order to be "saved" from ERISA preemption. *CIGNA Healthplan v. Louisiana*, 82 F.3d 642, 650 (5th Cir.), *cert. denied*, 117 S.Ct. 387 (1996); *Tingle v. Pacific Mut. Ins. Co.* 996 F.2d 105, 108 (5th Cir. 1993). The *Cisneros* decision acknowledged this direct conflict. 134 F.3d at 946. In deed, the conflict is even more widespread as shown by *Tingle's* observation that "[t]he Eleventh, Sixth, Tenth and Eighth Circuits have all held that a statute's failure to satisfy one or more of the *Metropolitan Life* factors excludes it from the ERISA saving insurance clause." 996 F.2d at 110. Most recently in *Davies v. Centennial Life Ins. Co.*, 128 F.3d 934, 940 (6th Cir. 1997), the Sixth Circuit acknowledged the widening Circuit conflict as to whether all three McCarran-Ferguson factors are required, holding that "no single one is dispositive." It followed *Cisneros* and provided a *but see* reference to the Fifth Circuit's *CIGNA* decision.

The Ninth Circuit's holding that the "saving" clause does not require satisfaction of the first prong of the McCarran-Ferguson test—the actual spreading or transfer of the risk of loss—further conflicts with the holdings of the Third, Seventh, Eighth, Tenth and Eleventh Cir-

cuits, all of which have uniformly ruled that state laws which fail to spread or transfer an insurance policyholder's risk, an "indispensable characteristic of insurance," *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211-213 (1979), are not saved from preemption by ERISA § 514(b)(2)(A).[6]

The Ninth Circuit's preemption decision not only destroys the national uniformity of law in plan administration that is one of ERISA's chief goals, but also causes a Circuit split that is certain to widen in the future and encompass additional state law rules. This Court need look no further than two companion cases involving petitioner UNUM for a sampling of what the Ninth Circuit has in store for ERISA preemption law and ERISA plan sponsors. *See Cisneros*, petition for a writ of certiorari filed concurrently herewith (the same "notice-prejudice" rule at issue herein); *Williams v. UNUM Life Ins. Co.*, 113 F.3d 1108, 1113 (9th Cir. 1997) (California's "rolling accrual" proof of loss provision (each monthly failure to pay benefits constitutes a new cause of action) may void an ERISA plan's limitation of actions provision). The Ninth Circuit's reasoning in both of those cases is the same as its reasoning in the present case. It was because of the significant consequences the Ninth and Sixth Circuits' new preemption holdings will have on

[6] *Insurance Bd. v. Muir*, 819 F.2d 408, 412 (3d Cir. 1987) (state law which does not affect transfer of risk or satisfy any other McCarran-Ferguson Act factor is preempted); *Tingle*, 996 F.2d at 108 (state law which fails to transfer risk is preempted); *McMahan v. New England Mut. Life Ins. Co.*, 888 F.2d 426, 428-30 (6th Cir. 1989) (state law which fails to transfer risk or satisfy third factor is preempted); *DeBruyne v. Equitable Life Assurance Soc.*, 920 F.2d 457, 468-70 (7th Cir. 1990) (same); *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 153-54 (8th Cir. 1990) (state law which fails to transfer risk is preempted); *cert. denied*, 501 U.S. 1238 (1991); *Kelley v. Sears, Roebuck & Co.*, 882 F.2d 453, 455-56 (10th Cir. 1989) (state law which fails to transfer risk or satisfy second factor is preempted); *Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467, 1468-69 (11th Cir. 1988) (same).



insured plans that a petition for a writ of certiorari has been filed concurrently in the *Cisneros* case.

This acknowledged Circuit conflict on a significant ERISA preemption issue is alone sufficient ground for this Court's review.

## II. THE NINTH CIRCUIT'S PREEMPTION DECISION CONFLICTS DIRECTLY WITH NINE OTHER CIRCUITS WHICH ENFORCE WRITTEN PLAN PROVISIONS SUCH AS NOTICE REQUIREMENTS.

Still another reason supports the granting of a writ of certiorari. In a direct clash with ERISA's plain language and decisions from nine other Circuits, the Ninth Circuit's adoption of the "notice-prejudice" and *"Elfstrom"* rules will allow state common-law claims in one or more states to *void* a number of ERISA's key substantive provisions and prohibit written plan notice requirements permitted by ERISA. In so doing, the decision not only destroys ERISA's goals of a *"uniform body of benefit law"* and the *"nationally uniform administration"* of plans, *National Conf. of Blue Cross-Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1996) (citation omitted) (emphasis added) (*"Travelers"*), but also overlooks significant constraints which ERISA, this Court and the other Circuits have imposed on the adoption of state common-law principles in the employee benefit field.

As set forth in more detail at pages 8 to 14 of the petition for a writ of certiorari in *Cisneros*, ERISA is a " 'comprehensive and reticulated statute,' the product of a decade of congressional study of the nation's private employee benefit system." *Mertens v. Hewitt Associates*, 508 U.S. 248, 251 (1993) (citation omitted). One of ERISA's purposes is to avoid a "multiplicity of regulation", a " 'conflict in . . . law' " and ' " conflicting directives' " between federal and state regulatory systems. *Travelers*, 514 U.S. at 656-657. ERISA contains a preemption clause in § 514(a) which, among other effects,

preempts state laws that "mandate[] employee benefit structures or their administration," "prohibit" what is "permitted" by federal law, "preclude uniform administrative practice," or provide "alternate enforcement mechanisms." 29 U.S.C. § 1144(a); 514 U.S. at 657-658, 660. In striking a balance between competing federal and state interests, Congress made the administration of both insured and self-funded ERISA plans, including claims processing, " 'exclusively a federal concern.' " *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987) (citation omitted). Congress intended to "minimize[] the need for interstate employers to administer their plans differently in each State in which they have employees." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983).

To ensure uniformity of law, Congress enacted a broad array of national, uniform fiduciary standards to govern the administration of both self-funded and insured ERISA plans. ERISA §§ 401-414, 503, 29 U.S.C. §§ 1101-1114, 1133. Indeed, Congress codified federal "trust" principles in ERISA not merely to ensure "*uniformity*," but also to ensure that certain "plans, such as insured plans, which do not use the trust form as their mode of funding," would be subject to the same exacting standards.[7]

Additionally, one "of ERISA's purposes is to protect the financial integrity of pension and welfare plans by confining benefits to the terms of the plan as written." *Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126, 128 (7th Cir. 1992) (Posner, J.) ERISA's "written plan instrument" rule, one of ERISA's "core functional requirements," *Curtis-Wright Corp. v. Schoonejongen*, 514 U.S. 78, 84 (1995), assists in ensuring the nationally uniform administration of plans. It requires that all plans—self funded and insured alike—be in writing and be administered by fiduciaries "*in accordance with*" their

[7] H.R. Rep. No. 533, 93d Cong., 1st Sess. 12 (1973) 2 Legislative History of the Employee Retirement Income Security Act at 2359 (emphasis added).



written terms to the extent not inconsistent with ERISA. ERISA §§ 401(a), (b), 404(a)(1)(D), 29 U.S.C. §§ 1102(a), (b), 1104(a)(1)(D) (emphasis added).[8] Moreover, ERISA's exclusive civil enforcement provisions ensure the same goals, authorizing suit *only* if benefits are "due" under those written terms. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B); *Pilot Life*, 481 U.S. at 52-57.

Apart from the Ninth Circuit, the Courts of Appeals have consistently carried forward ERISA's goal of a uniform national body of law to govern plan administration by holding that ERISA preempts state common-law "notice" rules or "notice" statutes, or state law agency rules, all of which vary from state to state. The decisions' rationale is that these state laws not only "relate to" ERISA plans, but also conflict either with the sponsor's freedom of plan design or the Act's comprehensive regulatory scheme. *See, e.g., Nazay v. Miller*, 949 F.2d 1323, 1336-1337 (3d Cir. 1991) (ERISA preempts "notice-prejudice" rule with respect to self-funded plan); *Howard v. Gleason Corp.*, 910 F.2d 1154, 1157-1158 (2d Cir. 1990) (ERISA preempts state statute requiring a terminated employee be notified of insurance conversion options); *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 571 (11th Cir.) (ERISA preempts state statute governing notice to insured of termination of coverage), *cert. denied*, 513 U.S. 808 (1994); *Doe v. Blue Cross & Blue Shield United*, 112 F.3d 869, 874-875 (7th Cir. 1997) (ERISA plan's internal limitations period controls over state statute); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488-1490 (7th Cir. 1996) (ERISA preempts state law agency claims related to a denial of plan benefits).

[8] The plan documents, which include the "contract or other instruments under which the plan is established or operated," encompass group insurance policies. ERISA § 104(a)(1), (b)(2); *see e.g., Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277, 280 (11th Cir. 1987); *Roe v. General American Life Ins. Co.*, 712 F.2d 450 (10th Cir. 1983).

Furthermore, other Circuits have consistently held that ERISA precludes the use of any state or federal doctrines —similar to the two state law rules involved here—that would cause a departure from the plan's unambiguous written terms, or any of ERISA's carefully-drawn statutory provisions which ensure uniformity in plan administration. *See, e.g., Nachwalter v. Christie*, 805 F.2d 956, 960 (11th Cir. 1986) ("federal courts may not use state common law to re-write a federal statute"); *Member Services Life Ins. Co. v. Amer. National Bank and Trust Co.*, 130 F.3d 950, 957-958 (10th Cir. 1997) (courts cannot "rewrite [ERISA] to satisfy [their] proclivities"); *Pohl*, 956 F.2d at 128 (ERISA "confin[es] benefits to the terms of the plan as written"); *Hunt v. Hawthorne Associates, Inc.*, 119 F.3d 888, 891 (11th Cir. 1997) ("[t]he cornerstone of an ERISA plan is the written instrument"); *Edwards v. Great-West Life Assur. Co.*, 20 F.3d 748, 750 (7th Cir. 1994) (courts cannot "rewrit[e] the plan"); *Burnham v. Guardian Life Ins. Co.*, 873 F.2d 486, 490 (1st Cir. 1989) (same); *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 56, 59 (4th Cir. 1992) (same), *cert. denied*, 506 U.S. 1081 (1993); *Boyer v. Douglas Components Corp.*, 986 F.2d 999, 1005 (6th Cir. 1993) (same); *Cefalu v. B.F. Goodrich Co.*, 871 F.2d 1290, 1295-1296 (5th Cir. 1989) (same).

The Ninth Circuit's decision on the "notice-prejudice" and "*Elfstrom*" rules not only directly conflicts with other Circuits, but also will spur additional litigation across the country as plan participants whose claims would be barred under the provisions of ERISA seek refuge in the more generous provisions of state law. If one or two judicial revisions of ERISA's text governing fiduciary duties and civil enforcement are appropriate through artful but erroneous readings of the preemption and "saving" clauses, plaintiffs and the lower courts will ask, why not twenty? If twenty, why not two hundred? This departure from the national uniformity of law required by ERISA, the chaos in plan administration and the increased litigation and



transaction costs will only lead plan sponsors to a reduction or elimination of benefits, *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 13 (1987), all in conflict with the "public interest in encouraging the formation of employee benefit plans," *Pilot Life*, 481 U.S. at 54.

As explained in more detail at pages 12-14 of the petition in *Cisneros*, the Ninth Circuit's decision frustrates yet another principle central to ERISA's statutory scheme—the orderly internal resolution of benefit disputes as a prerequisite to filing suit under the Act's civil enforcement system. Notice of claim deadlines are not only standard features of many ERISA plans, but they also protect against the difficulties of proof, expenses and errors associated with stale claims.[9] A plan's written procedures and time limits for the filing of ERISA claims,[10] no less than the ERISA fiduciary review procedure required by § 503, are essential steps in the plan's administrative remedies.[11] A significant part of this Court's *Pilot Life* holding is that ERISA suits must be regarded as arising under federal law in a manner similar to those under § 301 of the Labor-Management Relations Act ("LMRA"). 481 U.S. at 55-56. Under § 301, an agreement's administrative remedies —including its written requirements and time limits for filing a claim—must be followed as a prerequisite to filing

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[9] *Central States, Southeast and Southwest Areas Pension Fund v. Mississippi Warehouse Corp.*, 853 F.Supp. 1053, 1058 (N.D. Ill. 1994); *Tiger v. AT&T Tech. Plan for Employees' Pensions, Disability Plan*, 633 F.Supp. 532, 534 (E.D. N.Y. 1986).

[10] 29 C.F.R. § 2560.503-1(b), (c).

[11] *See Kinkead v. Southwestern Bell Sick & Acci. Corp. Disability Benefit Plan*, 111 F.3d 67, 68 (8th Cir. 1997); *Kennedy v. System One Holdings, Inc.*, 835 F.Supp. 947, 950 n. 3 (S.D. Tex. 1993); *Christie v. K-Mart Corp. Employees Retirement Pension Plan*, 784 F.Supp. 796, 804 (D. Kan. 1992); *see also White v. Jacobs Engineering Group Long Term Disability Plan*, 896 F.2d 344, 346-47 (9th Cir. 1990) (plan's 60 day time limit for appealing denied claim is enforceable).

suit.[12] In permitting Ward's suit to proceed in admitted violation of the Plan's requirements, the decision below defers to the plaintiff but only at the cost of cutting across the grain of uniform federal law under ERISA, its antecedents in § 301 of the LMRA, and recent decisions by this Court. The carefully-crafted nature of ERISA's statutory scheme precludes the Ninth Circuit's continuing efforts to use state law doctrines to rewrite plan provisions and "fine-tune" the statute in favor of participants. *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 147-148 (1985); *Pilot Life*, 481 U.S. at 54.

## III. THE NINTH CIRCUIT'S PREEMPTION DECISION COMPLETELY DISRUPTS THE UNIFORMITY OF LAW INTENDED BY CONGRESS.

The Ninth Circuit's decision adopting the "*Elfstrom*" and "notice-prejudice" rules should be reviewed not only because it creates significant conflicts among the Circuits on ERISA preemption, but also because it has a far-ranging impact which destroys ERISA's key objectives of governing the administration of *both* self-funded and insured plans in accordance with an exclusive, uniform body of federal law. As this Court has noted, the "potential for conflict in substantive law" is "[*p*]*articularly disruptive*" under ERISA. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (emphasis added). The decision's severe repercussions—which will create a crazy quilt of conflicting plan rules across the land—warrant swift intervention by this Court.

The Ninth Circuit's new ERISA preemption standard, announced in connection with the "*Elfstrom*" rule, is so narrow and restricted, and the Court's disregard for conflicts-preemption is so complete, that the standard reopens

[12] *See, e.g., Laws v. Calmat*, 852 F.2d 430, 434 (9th Cir. 1988); *Brazinski v. Amoco Petroleum Additives Co.*, 6 F.3d 1176, 1179 (7th Cir. 1993); *Vaca v. Sipes*, 386 U.S. 171, 184-185 (1967).



a door closed by *Pilot Life* to state law suits based on virtually any claim arising out of a denial of plan benefits. Similarly, the Court's new standard for construing ERISA's "saving" clause is so broad and indiscriminate that it will arguably include virtually any common-law rule of general application that can be identified with the insurance industry regardless of whether it conflicts with ERISA's substantive provisions. Under the combined effect of these two standards, ERISA plan design, administration and civil enforcement will be challenged by an almost unlimited range of state laws. This will both conflict with *Pilot Life*, as discussed in more detail in section IV, below, and, at the same time, resurrect the same obstacles to plan growth and development—the "multiplicity of regulation" and " 'conflict . . . in law' "—that the Act was designed to eliminate. *Travelers*, 514 U.S. at 656-657 (citation omitted).

In misconsrtuing ERISA's preemption and "savings" clauses, the Ninth Circuit's decision produces a result exactly opposite to ERISA's fundamental purposes. To require all ERISA plans to be administered the same way in each state, Congress carefully crafted each of the Act's major components. It framed the definition of employee benefit plans explicitly to include *all* plans whether established "through the purchase of insurance or otherwise." ERISA § 3(1). It also inserted a "deliberately expansive" preemption provision designed to make the regulation of all ERISA plans " '*exclusively a federal concern.*' " *Pilot Life*, 481 U.S. at 45-46 (citation omitted) (emphasis added). Similarly, it added a "deemer" clause which precludes any plan from being "deemed" an "insurance company" or "engaged in the business of insurance." ERISA § 514(b)(2)(B). This significant qualification to the "saving" clause—which was completely overlooked by the Ninth Circuit—reflects Congress' commitment to free the administration of insured plans from the possibility of state regulation through some artful or overly-broad construction of the insurance exception. The "deemer" clause makes explicit Congress' objectives to

achieve federal uniformity in benefits law and plan administration by barring direct state regulation of plans irrespective of their funding mechanisms. When the "deemer" clause is thus read in conjunction with the Act's key objectives, it is clear that state regulation impacting plan administration and benefit payment—regulation which strikes at the very core of ERISA—would be preempted, notwithstanding that plan administration is conducted in part by an insurance company or a Blue Cross/Blue Shield organization.

**A. Disruptions Caused By The "Notice-Prejudice" Rule.**

The disruptions caused by the Ninth Circuit's error in allowing a state law rule, such as the "notice-prejudice" rule, to seize control over plan structure and administration, and the resulting conflict with ERISA's goals and *Pilot Life*, are discussed in detail at pages 18 through 22 of the petition for a writ of certiorari in the *Cisneros* case.

**B. Disruptions Caused By The *"Elfstrom"* Rule.**

In finding the California agency law announced in *"Elfstrom"* not preempted, the Ninth Circuit's decision not only once again flouts *Pilot Life*, but also conflicts with the law in other Circuits and produces a disruptive result that is contrary to ERISA's objectives. Apart from the Ninth Circuit, the courts have held that ERISA § 514(a) preempts state common-law agency doctrines which impact plan administration and the payment of benefits and thus "conflict with Congress' intent that a plan not be subject to a myriad of state laws." *See, e.g., Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488-1490, 1493 (7th Cir. 1996) (ERISA preempts state law agency claims relating to a benefit denial). The decision below plainly conflicts with the Seventh Circuit's agency law decision in *Jass*. In addition, field preemption and conflicts-preemption bar the decision below because the common-law agency rule clashes



with ERISA's exclusive framework regulating fiduciary responsibility, claims-filing and civil enforcement.

In its haste to subject ERISA plans to state law control, the Ninth Circuit did not correctly analyze whether California agency law "relates to" an ERISA plan within the meaning of § 514(a) or is barred by field or conflicts-preemption. Instead, it mechanically applied state agency law based on a single, outdated, impliedly-overruled case, *Turrill v. Life Ins. Co. of North America*, 753 F.2d 1322 (5th Cir. 1985), which permitted state law to govern the administration of an insured ERISA plan. The Ninth Circuit failed to recognize the significance of the point that *Turrill* was decided *prior* to *Pilot Life* at a time when the courts consistently but incorrectly believed that ERISA preemption did not apply to suits alleging improper claims-handling or failure to pay benefits under insured plans. Accordingly, it was an anachronistic, direct contravention of *Pilot Life* for the Ninth Circuit to hold that ERISA does not preempt state law doctrines governing claims filing and benefit payment under an insured ERISA plan.

Four equally valid arguments establish that ERISA preempts state law agency rules such as the one embodied in *"Elfstrom,"* thus barring a multiplicity of federal-state regulation. First, the state law plainly "relates to" the Plan under the "ordinary meaning" of that term because it purports to regulate claims filing and processing and thereby dictates the payment of plan benefits. Indeed, Ward is attempting to use state law not only to assert the timely, oral "filing" of an ERISA claim with his employer, but also to bind the Plan's claims review fiduciary to such "filing" and obtain benefits precluded by the Plan's written terms. The state law thus has an obvious " 'connection with or reference to such a plan.' " *See Pilot Life*, 481 U.S. at 47-48; *District of Columbia v. The Greater Washington Bd. of Trade*, 506 U.S. 125, 129 (1992).

"ERISA is designed to ensure the proper administration of pension and welfare plans." *Boggs v. Boggs*, 117

S.Ct. 1754, 1760 (1997). Acknowledging the need for uniformity of law, other Circuits have correctly held that ERISA § 514(a) preempts state agency law in a suit involving a denial of plan benefits. In *Jass, supra,* which involved a suit to hold a plan responsible for a medical provider's conduct in denying plan benefits, the Seventh Circuit held that the state agency law "related to" an ERISA plan and was therefore preempted by § 514(a). 88 F.3d at 1494. The court found that the agency argument was based on the plan's existence; the plan documents expressly stated that no agency relationship existed; the agency claim was a mechanism for seeking *benefits* not permitted by the plan documents; and applying state law would conflict with Supreme Court holdings that ERISA preempted " 'state laws that had the effect of regulating the structure or administration of ERISA plans or providing avenues outside of the ERISA framework to vindicate employees' rights under these plans' " (citation omitted). Both the holding and reasoning of the Seventh Circuit are in conflict with the decision below. *See also Perkins v. Time Ins. Co.*, 898 F.2d 470 (5th Cir. 1990) (under ERISA, personal liability of another party cannot be imputed to insurer under agency law theory).

Second, in cases where the direct relationship between the plan and the state law is not so immediately obvious as the one here, this Court has held that whether the law "relates to" the plan within the meaning of ERISA § 514(a) should be based on " 'the objectives of the ERISA statute . . . as well as . . . the nature of the effect of the state law on ERISA plans.' " *California Div. of Labor Standards Enforcement v. Dillingham Const.*, 117 S.Ct. 832, 838 (1997) (citation omitted). Under this analysis, ERISA preempts state law that would *frustrate* ERISA's goals by imposing different regulations from state to state, or by permitting claimants governed by one state law to obtain "benefits in excess of what plan administrators intended to provide, and in excess of what the plan provided to employees in other States." *Travelers,* 514 U.S.



at 656-657, 658. State laws cannot "preclude uniform administrative practice." *Id.* at 660. The state agency law adopted by the Ninth Circuit spawns *all* of these vices by subjecting plan administration and benefit payment to a multiplicity of regulation not only between federal law and state law, but also—for multistate employers—among the conflicting laws of the 50 states.

Third, the Ninth Circuit's decision disrupts the uniformity of regulation secured by ERISA's fiduciary responsibility provisions. ERISA's fiduciary and co-fiduciary liability rules impose *personal* liability and damages on a fiduciary for its *own* acts causing loss to a plan. ERISA § 409(a); *Russell,* 473 U.S. at 139. The court, however, permitted Ward to proceed on a state law agency theory that UNUM, as a "principal" and co-fiduciary, was personally liable for any ERISA violation by the employer in failing to ensure that he timely filed a written notice and proof of claim with UNUM. App. at 24a to 25a. As indicated, Ward was a CEO who admittedly had received a certificate of coverage which described the procedures and deadlines for submitting a claim to UNUM, and also participated in annual meetings where the Plan was reviewed. *Id.* at 29a, 32a to 33a. ERISA did not require the employer to do still more. ERISA's reporting and disclosure rules "may not be a foolproof informational scheme, although it is *quite thorough.* Either way, *it is the scheme that Congress devised.*" *Curtiss-Wright,* 514 U.S. at 84 (emphasis added). Even if the employer had violated ERISA by not seeking Ward out to give him further, specialized information about claims-filing, the Ninth Circuit still erred in permitting him to use state law agency doctrine to impute such a violation to UNUM as a co-fiduciary. App. at 25a. ERISA explicitly places the reporting and disclosure obligations *personally* on the Plan Administrator, §§ 105(b)(1), 502(c), and no other party can be held liable for such a violation, *see, e.g., McKinsey v. Sentry Ins. Co.*, 986 F.2d 401 (10th Cir. 1993). Further, ERISA's co-fiduciary liability rules im-

pose liability only where the co-fiduciary has *actual knowledge* of a breach by its co-fiduciary but fails to act.[18] Within the Plan's time limit for filing written notice and proof of claim, UNUM had no knowledge that Ward claimed to be "disabled" or had purportedly so advised his employer.

Fourth, the state law agency rule adopted by the Ninth Circuit runs afoul of conflicts-preemption and the exclusivity of ERISA's civil enforcement scheme for dual reasons. First, it conflicts with ERISA's fiduciary responsibility rules; second, it seeks to control benefit payment contrary to the Plan's written terms. In an attempt to suggest otherwise, the Ninth Circuit opined: "[N]or does *Elfstrom* create an 'alternative enforcement mechanism' for ERISA plan obligations beyond those set forth in the statute." App. at 21a to 22a. This conclusion is 180 degrees off course. The decision below provides the clearest possible example of an "alternate enforcement mechanism" triggering ERISA preemption. It would permit a state law rule to require the *payment* of plan benefits under circumstances where a claim denial is mandated by the Plan itself, ERISA's fiduciary responsibility rules and its exclusive civil enforcement scheme.

## IV. THE NINTH CIRCUIT'S PREEMPTION DECISION IS AN ATTEMPT TO CIRCUMVENT THIS COURT'S CONTROLLING *PILOT LIFE* DECISION.

The holding and reasoning of this Court's unanimous decision in *Pilot Life* also preclude the Ninth Circuit's holdings that in a suit to recover plan benefits the "notice-prejudice" and "*Elfstrom*" rules escape ERISA preemption.

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[13] ERISA § 405(a)(1), (3); H.R.Rep. No. 1280, 93d Cong., 2d Sess. 304 (1994) (actual knowledge is required; there is no duty of investigation); *Davison v. Cook*, 564 F.Supp. 225, 237 (E.D. Va. 1983), *aff'd. mem.*, 734 F.2d 10 (4th Cir. 1984), *cert. denied* sub nom., *Accardi v. Davidson*, 469 U.S. 899 (1984); *Justice v. Bankers Trust Co., Inc.*, 607 F.Supp. 527, 536 (D.C. Ala. 1985).



*Pilot Life* held that ERISA preempts state law causes of action alleging an insurance company's "improper processing of a claim" and failure to pay plan benefits. It held that these causes of action plainly "related to" the plan and were not preserved by the "saving" clause. Additionally, it held that ERISA would bar these causes of action—even if the "saving" clause were applicable—because they conflict with one of ERISA's substantive provisions, its exclusive civil enforcement scheme in § 502(a). 481 U.S. at 51-57. In the present case, the Ninth Circuit concluded that Ward's failure to submit timely proof of his claim as required by the Plan does not necessarily invalidate his claim under § 502(a)(1)(B) in light of the "notice-prejudice" rule. It also permitted him to go forward under a state law agency rule which clashes with ERISA's intricate framework for claims-filing and processing, plan administration and fiduciary responsibility. The decision permits the identical result prohibited by *Pilot Life*: state common law rules purporting to govern the processing of claims allow a recovery that is both unavailable under the plan and in conflict with ERISA's substantive provisions, here its fiduciary responsibility and civil enforcement sections.

The Ninth Circuit's decision on the two state law rules contravenes not only the Court's holding in *Pilot Life* but also its reasoning. In *Pilot Life*, the Court first held that ERISA § 514(a) preempts state causes of action based on allegedly improper processing of claims and failure to pay benefits because such actions manifestly "relate to" an ERISA plan in the sense of having " 'a connection with or reference to such a plan.' " 481 U.S. at 47-48. In construing ERISA's "saving" clause, the Court evaluated Mississippi's "law of bad faith" under the common-sense and McCarran-Ferguson Act tests, then ruled that "we are obligated in interpreting the saving clause to consider . . . [its] role . . . in ERISA as a whole." Because the plaintiff's "bad faith" claims sought remedies for improper claims processing and failure to pay benefits, a sub-

ject already addressed in ERISA's enforcement scheme, the Court reasoned that "our understanding of the 'saving' clause must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA section 502(a)." *Pilot Life*, 481 U.S. at 52. The Ninth Circuit completely failed to consider the preemption and "saving" clauses in this broader context.

To determine legislative intent, this Court evaluated the structure, language and purposes of the statute. First, the Court observed that § 502 is one of three statutory sections aimed at enforcing ERISA; the other two are § 503, governing the processing of claims and the fiduciary review of denied claims, and § 501, which provides criminal penalties for certain violations. *Pilot Life*, 481 U.S. at 52-53. Second, the Court noted that the language of the statute does not provide for the extra-contractual damages and other remedies that the plaintiff was seeking against the insurance carrier. Rather,

> the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others . . . would be completely undermined if ERISA-plan participants . . . were free to obtain remedies . . . that Congress rejected in ERISA.

*Pilot Life*, 481 U.S. at 54. Third, the Court determined that Congress intended to model ERISA's civil enforcement provisions upon § 301 of the LMRA which "preempts any 'state-law claim whose resolution is substantially dependent upon the analysis of the terms of an agreement made between the parties in a labor contract.'" *Id.* at 55 (citation omitted). Thus, Congress intended "that *all* suits . . . asserting improper processing of [ERISA] claims . . . be treated as federal questions governed by § 502(a)." *Id.* at 56 (emphasis added).



Ward's claim based on the two state law rules fails under this analysis for a panoply of reasons. ERISA preempts a state law cause of action based on a fiduciary's failure to pay plan benefits. Under *Pilot Life*, such a claim obviously "relates to" an ERISA plan and is preempted by § 514(a). Similarly, not only field preemption but also conflicts-preemption bar Ward's state law claims pursuant to *Pilot Life*. ERISA §§ 502(a), 503 and 29 C.F.R. § 2560.503-1(c)-(g) contain detailed, exclusive provisions governing the filing and processing of ERISA claims, and the filing of suits for relief when administrative remedies are exhausted. Section 503 requires "*every* employee benefit plan" to comply with benefit claims regulations issued by the Secretary of Labor (emphasis added). Those regulations, in turn, specify that a plan's claims procedure may provide for the filing of claims with an insurance company, and that "a claim is filed when the requirements of a reasonable claim filing procedure . . . have been met." 29 C.F.R. § 2560.503-1(c)(d). Under ERISA's fiduciary review procedure for denied claims, the "fiduciaries" include an insurance company, or a Blue Cross/Blue Shield organization, serving as claims review fiduciary. *Id.* at § 2560.503-1(g)(2). By statute, these fiduciaries must follow the plan's written terms. ERISA § 404(a)(1)(D). Correspondingly, a participant who exhausts those administrative procedures may only file suit to recover benefits "*due* . . . under the *terms* of [the] plan." ERISA § 502(a)(1)(B) (emphasis added). This exclusive structure for fiduciary responsibility and civil enforcement would be "completely undermined if ERISA-plan participants" such as Ward could use state law doctrines to obtain benefits contrary to the plan's written terms and ERISA's civil enforcement scheme. *Pilot Life*, 481 U.S. at 54. Accordingly, the *Pilot Life* analysis precludes the decision below.

## V. THE QUESTIONS PRESENTED BY THIS PETITION HOLD IMPORTANT IMPLICATIONS FOR ERISA PLANS THAT SHOULD BE ADDRESSED BY THIS COURT.

The Ninth Circuit's decision adopting the state law "notice-prejudice" and agency rules will impose a multiplicity of conflicting federal-state regulation on insured ERISA plans. Additionally, it will surrender significant portions of ERISA plan administration to the varying laws in the 50 states. All of this runs exactly contrary to ERISA's primary goals of ensuring a "uniform body of benefits law," *Travelers*, 514 U.S. at 645, making the administration of both self-funded and insured plans "'exclusively a federal concern,'" *Pilot Life*, 481 U.S. 45-46 (citation omitted), and "minimiz[ing] the need for interstate employers to administer their plans differently in each state in which they have employees," *Shaw*, 463 U.S. at 105.

Unless corrected, the Ninth Circuit's decision along with the Sixth Circuit's decision in *Davies*, 128 F.3d at 940—coupled with the Circuit conflicts over ERISA preemption—will create enormous confusion and difficulty in the design and administration of thousands of insured welfare plans across the country. Exactly the same hardships will affect pension plans with insurance funding. This confusion and uncertainty will spread into the courts as claim denials which are clearly proper under ERISA are made uncertain by the imprecise parameters of the Ninth Circuit's new view of the "saving" clause, and its narrow reading of the scope of ERISA preemption. Additionally, the adverse effects will not be limited to plan administration within the Sixth or Ninth Circuits. ERISA provides for nationwide service of process, and permits a suit to be filed in any district where the plan is administered, the breach of fiduciary duty took place, or a defendant resides or may be found. ERISA § 502(e)(2); *see, e.g., Varsic v. United States Dist. Ct.*, 607 F.2d 245, 248 (9th Cir. 1979). Consequently, the vast majority of insured plan sponsors coast to coast now risk not only that



the structure of their plans may be overturned, but also that the plan's administration and benefit payments may be subject to conflicting federal and state regulation pursuant to the Ninth Circuit's unprecedented decision and the parallel Sixth Circuit decision.

The practical consequences of the Ninth and Sixth Circuits' decisions are staggering. Just in terms of major medical care plans alone, there are an estimated 4.5 million employer-sponsored plans [14] covering over 161 million individuals.[15] Overwhelming percentages of these plans either are insured, with a large subset being Blue Cross/Blue Shield plans, or are self-funded plans with stop-loss insurance.[16] More than 9 out of 10 such plans delegate some portion of ERISA claims-handling and payment—and the fiduciary review authority mandated by ERISA § 503—to insurance companies, Blue Cross/Blue Shield organizations or third-party administrators.[17]

Across the nation, plan sponsors need to be able to design insured ERISA plans without fear that their written terms will be overturned in one state or another through some artful but erroneous application of ERISA's preemption and "saving" clauses. The loss of discretion over plan design will only provide a strong disincentive to establish such plans in the first place. *See, e.g., Heath v. Varity Corp.*, 71 F.3d 256, 258 (7th Cir. 1995). Additionally, the "notice-prejudice" rule has been rejected by many states and varies considerably across the land; [18]

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[14] ADMINISTRATION OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT, REPORT OF THE SECRETARY OF LABOR TO CONGRESS at i (1987).

[15] STATISTICAL ABSTRACT OF THE UNITED STATES, p. 120 (117 ed. 1997).

[16] MERCER/FOSTER HIGGINS NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS, Report 1997, 17-18.

[17] *Id.* at 18.

[18] Many jurisdictions consider a timely claim as a condition precedent to recovery and thus do not follow such a rule. Other states presume prejudice to the insurer and require the claimant to estab-

similarly, state agency law doctrines vary from state to state.[19] All of this practical uncertainty coupled with the differences in state law will create strong financial incentives for employers either to cut back or eliminate insured benefits altogether, or to use self-funded plans notwithstanding the greater stability and solvency of insured plans.

The plan administrators and claims review fiduciaries for these plans, moreover, can be expected to process literally millions of ERISA claims for disability, pension and health benefits annually. Unless this Court resolves the Circuit conflicts, it will be impossible for these administrators and fiduciaries to rely on a " 'uniform body' " of federal benefits law, or to engage in the "nationally uniform" plan administration which was a "basic thrust" of ERISA. *Travelers*, 514 U.S. at 656-657. Further, they will be unable to administer their plans both in compliance with the plans' written terms and the Ninth Circuit's decision. They cannot know whether to deny a claim on the basis of a clear plan limit, or to accept the claim under state law regarding "notice-prejudice" or agency without regard to the terms of their plan and thus breach an ERISA fiduciary duty. They cannot even know which opposing sets of federal and state laws to apply to determine those questions.

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lish its absence; still other states—such as California—require the insurer to prove "actual prejudice." *See* 13A George J. Couch *et al.*, *Couch Cyclopedia of Insurance Law* § 49.49 at 276-77 (2d ed. 1982).

[19] *See, e.g., Metropolitan Life Ins. Co. v. Henry*, 217 Ind. 33, 24 N.E.2d 918 (1940) (under Indiana law, employer acting as middleman between insurer and employees is agent of employees); *First National Bank of Anson County v. Gatewood*, 303 N.C. 203, 214-15 278 S.E.2d 507 ("case law in this jurisdiction [North Carolina] . . . establishes that the employer-master policyholder is not ordinarily the agent of the insurer"); *Brezan v. Prudential Insurance Co. of America*, 507 F.Supp. 962, 966 (E.D.Pa. 1981) (under Pennsylvania law, group policyholder has no obligation to ensure that terms of group policy are correctly transmitted to employees); *Dawes Mining Co. v. Callahan*, 246 Ga. 531, 272 S.E.2d 267 (1980) (in Georgia, employer is agent of insurer, and insurer has imputed knowledge of information transmitted to employer).



The Ninth Circuit acknowledged in *Cisneros* the direct conflict between California's "notice-prejudice" rule and ERISA, stating that the rule made the plan "*more difficult to administer*" and caused "a plan's written terms [to be] *altered*." 134 F.3d at 947 (emphasis added). In the same manner, the "*Elfstrom*" rule requires the payment of benefits under circumstances where the Plan itself and ERISA's fiduciary responsibility and civil enforcement provisions require a claim denial. The decision thus presents, in two important respects, a "*direct clash* between state law and the provisions and objectives of ERISA," one where preemption necessarily arises because " 'compliance with both federal and state regulations is a *physical impossibility*.' " *Boggs v. Boggs*, 117 S.Ct. 1754, 1762 (1997) (citation omitted) (emphasis added). To allow state law rules not only to encroach on ERISA's exclusive framework for fiduciary standards and plan administration—but to "alter" the plan's written terms, and to permit a suit for benefits contrary to those terms—completely undermines a number of ERISA's most significant and highly-regulated areas. It also wreaks havoc on the important principle of uniformity of law upon which ERISA is based.

Intervention by the Court is critical to restore the carefully-crafted balance between state and federal law struck by Congress in ERISA and to reestablish the preeminence of ERISA's statutory scheme. ERISA plans are not only "affected with a national public interest," § 2(a), 29 U.S.C. § 1001(a), but the appropriate balance between competing federal and state law is of paramount concern to the nation's employee benefit plan system. Given the "centrality of pension and welfare plans in the national economy," *Boggs v. Boggs*, 117 S.Ct. at 1760, it is vital that this Court decide the two significant, far-reaching ERISA preemption issues presented by this case, and resolve the existing Circuit conflicts.

## CONCLUSION

For the foregoing reasons, petitioner urges the Court to grant a writ of certiorari in this case.

Respectfully submitted,

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May 20, 1998

# APPENDIX

## APPENDIX TABLE OF CONTENTS


| | Page |
|---|---|
| Opinion of the Court of Appeals, filed February 3, 1998 | 1a |
| Order of the Court of Appeals denying Petition for Rehearing, with Suggestion for Rehearing en Banc, filed March 23, 1998 | 26a |
| Order of the District Court granting Summary Judgment, filed August 8, 1995 | 27a |
| Declaration of John A. Houser, III And Portions of Exhibits In Support of Motion for Summary Judgment, filed June 26, 1995 | 34a |
| Exhibit Portions (MacQuarrie and Ward Deposition Excerpts) to Declaration of Jeffrey P. Smith, filed June 26, 1995 | 73a |
| District Court Complaint, filed September 19, 1994 | 77a |
| ERISA § 2(a), (b), 29 U.S.C. § 1001(a), (b) | 99a |
| ERISA § 3(1), (16), 29 U.S.C. § 1002(1), (16) | 100a |
| ERISA § 402(a), (b), 29 U.S.C. § 1102(a), (b) | 101a |
| ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D) | 102a |
| ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) | 103a |
| ERISA § 503, 29 U.S.C. § 1133 | 103a |
| ERISA § 514(a), (b)(2)(A), (B), 29 U.S.C. § 1144(a)(b)(2)(A), (B) | 104a |
| 29 C.F.R. § 2560.503-1(b), (c), (g) | 105a |

**APPENDIX**

**UNITED STATES COURT OF APPEALS**
**NINTH CIRCUIT**

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No. 95-56269
D.C. No. CV-94-1454-MHH

Filed February 3, 1998

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JOHN E. WARD,
*Plaintiff-Appellant,*
v.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN, and UNUM LIFE INSURANCE COMPANY OF AMERICA,
*Defendants-Appellees.*

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Appeal from the United States District Court
for the Southern District of California

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Argued and Submitted January 9, 1997—
Pasadena, California

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Before Betty B. Fletcher and Stephen S. Trott,
Circuit Judges, and Bruce S. Jenkins,* District Judge

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* Honorable Bruce S. Jenkins, United States Senior District Judge for the District of Utah, sitting by designation.

## OPINION

JENKINS, District Judge:

John E. Ward ("Ward"), former President and CEO of Management Analysis Company ("MAC"), brought this action under § 502 of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1132, seeking to recover benefits pursuant to his former employer's long-term disability plan. The United States District Court for the Southern District of California granted summary judgment in favor of the Management Analysis Company Employee Disability Benefit Plan (the "MAC Plan") and UNUM Life Insurance Company of America ("UNUM") on the ground that Ward's claim for benefits under UNUM's long-term disability policy was timely under the notice and proof of claim provisions of that policy. In light of our ruling in a related case, Cisneros v. UNUM Life Insurance Company of America, —— F.3d —— (9th Cir. 1998), that under California law, UNUM must show actual prejudice resulting from a claimant's untimely submission of proof of a claim before it may deny benefits under a plan governed by ERISA, we reverse the judgment in favor of UNUM and the MAC Plan and remand the case for further proceedings. We also remand for a determination of whether MAC received timely notice and proof of Ward's claim of disability while acting as a plan fiduciary and agent of UNUM, should that determination become decisive of the question of timeliness.

### I

Effective November 1, 1983, UNUM issued a Group Long Term Disability Policy to MAC as an insured employee welfare benefit plan governed by ERISA. An employee certificate booklet summarizing the plan benefits was prepared and distributed in quantity to MAC employees, including Ward.



Ward served as President and Chief Executive Officer of MAC until, after being asked to resign by the Board of Directors on May 5, 1992, he resigned on May 8, 1992. In May of 1992, Ward was already suffering from diabetic neuropathy, and avers that prior to his resignation, he had begun experiencing severe and disabling leg pain resulting from that condition.

The nature and extent of his illness and resulting disability were diagnosed by December of 1992. In early 1993, Ward applied for and received state disability benefits, and contacted the MAC human resources division to discuss extension of his continuation insurance coverage under COBRA. In July 1993 he received a determination that he was eligible for Social Security disability benefits, a copy of which he forwarded to the MAC human resources division.

Ward states that he was actually unaware of the availability of the MAC Plan long-term disability benefits until April 1994, when he discovered a booklet describing the coverage among papers in his safety deposit box. Ward completed an application for long-term disability benefits and forwarded the same to MAC. MAC completed the employer information section of the application and forwarded the same to UNUM.

UNUM received notice and proof of Ward's claim on April 11, 1994. By letter dated April 13, 1994, UNUM informed Ward that his claim for benefits was denied as untimely under the terms of the policy. Through counsel, Ward requested that UNUM review the denial of his claim, and by letter dated July 12, 1994, UNUM informed Ward that it had reviewed his claim and affirmed its denial because it was "beyond the time frame stipulated in the policy."

Plaintiff filed his complaint against the MAC Plan to recover his claimed benefits under ERISA on September 15, 1994. UNUM appeared as a defendant and filed an

answer on behalf of itself and the MAC Plan on November 23, 1994. On August 8, 1995, the district court granted the defendants' motion for summary judgment, concluding that under the terms of UNUM's policy as written, "plaintiff's claim was late and therefore defendant was not obligated to honor plaintiff's claim for long-term disability benefits."

The district court entered judgment on August 17, 1995, and Ward filed a timely notice of appeal.

## II

We review the district court's grant of summary judgment de novo. Bagdadi v. Nazar, 84 F.3d 1194, 1197 (9th Cir. 1996). Whether ERISA preempts state law is a question of law which we review de novo. Inland Empire Chapter of Associated General Contractors v. Dear, 77 F.3d 296, 299 (9th Cir. 1996). We also review de novo the principles of contract interpretation as applied to the facts, including the district court's interpretation of insurance policy language. O'Neill v. United States, 50 F.3d 677, 682 (9th Cir.), cert. denied, 116 S. Ct. 672 (1995).

## III

While in his brief Ward lists several issues and makes a series of assertions concerning agency theory under Elfstrom v. New York Life Ins. Co., 67 Cal. 2d 503, 432 P.2d 731, 63 Cal. Rptr. 35 (1967), fiduciary duty under ERISA, and the potential liability of the MAC Plan, the appellees aptly restate the central issue now before us on appeal: "Did the District Court correctly hold that the plaintiff failed to timely submit written notice and proof of claim to UNUM as required by the express terms of the MAC Plan and applicable federal law under ERISA?"

UNUM expressly conditions payment of benefits upon submission of proof of claim within the time limits set forth in the policy. Section VI.F.2 of UNUM's policy



provides that proof "may not be given later than one year after the time proof is otherwise required," in this instance, "no later than 90 days after the end of the [90-day] elimination period." [1] Section VI.I provides that benefits will be paid "[w]hen the company receives proof of claim." Read together, these provisions logically and unambiguously establish that, under the policy, timely submission of proof is a condition precedent to payment of benefits.

Under the admitted facts of this case, Ward became permanently disabled on May 5, 1992. Using Ward's disability onset date of May 5, 1992, UNUM calculated that his proof of claim must have been received no later than November 5, 1993 in order to be deemed timely under the policy provision.[2] Ward did not submit notice or proof of his claim directly to UNUM until April 11, 1994. Ward's submission of notice and proof of his claim plainly was untimely under the express terms of the UNUM policy.

However, in light of our recent opinion in Cisneros v. UNUM Life Insurance Company of America, —— F.3d —— (9th Cir. 1998), untimeliness under the express terms of the policy does not end the inquiry, at least as to consequence. Cisneros holds that a claimant's failure to submit timely proof of claim does not necessarily result in the denial of benefits. Cisneros acknowledges that the California "notice-prejudice" rule remains in force respecting benefit plans governed by ERISA as a state law "which regulates insurance" under ERISA's savings clause, 29 U.S.C. § 1142(b)(2)(A). Under the "notice-prejudice" rule, the insurer of an ERISA benefit plan may not deny benefits by reason of untimely notice or submission of

---

[1] The MAC Plan documents provide that the "elimination period" consists of the 90-day period following the date of onset of the insured's disabilty.

[2] The district court's reference to a December 5, 1993 cutoff date appears to be simple mathematical error.

proof of claim unless the insurer proves that it has suffered actual prejudice because of the delay. Id. at 67375.[3]

Contrary to UNUM's assertion in its brief, we are not persuaded that passage of time alone establishes prejudice as a matter of law. See id. at 673, 675 (citing Shell Oil Co. v. Winterthur Swiss Ins. Co., 15 Cal. Rptr. 2d 815, 845 (Ct. App. 1993)). Whether UNUM suffered actual prejudice as a result of Ward's untimely notice remains a genuine issue of material fact. See Select Ins. Co. v. Superior Court, 276 Cal. Rptr. 598, 602 (1990). Thus, we reverse the district court's judgment in favor of UNUM.

Because neither the plan administrator nor the district court addressed the question of whether the notice-prejudice rule applied to Ward's claim, neither the plan administrator nor the district court determined whether UNUM suffered actual prejudice flowing from Ward's untimely notice and proof of claim.[4] Accordingly, we remand the case to the district court with instructions to remand to the plan administrator for a factual determination as to whether UNUM suffered actual prejudice by virtue of Ward's untimely submission of proof.

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[3] At the August 3, 1995 hearing on the motion for summary judgment, the district court inquired:

> THE COURT: Is there a body of law that then says that you have to—the company has to show some prejudice?
>
> MR. SMITH: No, not—not under ERISA. And we have cited as the Court knows, four cases, . . . all of which interpreted this plan language, and all of which, in circumstances almost identical to this, held that the proof of claim had not been timely provided—
>
> THE COURT: Now—MR. SMITH—really is under ERISA, and it is those cases that we would submit are controlling.

Among the four cases referred to by UNUM counsel was the district court disposition in the Cisneros case, now reversed on the precise issue raised by the court's question just quoted.

[4] While the district court noted in passing that "[t]he delay in filing precludes UNUM from definitively determining whether plaintiff's disability existed on the date alleged in his claim," the comment was made in the context of a broader policy discussion concerning time limits on claims rather than as a finding of fact based upon a specific evidentiary record. There appears to be little evidence in the present record bearing upon the question of actual prejudice. Paragraph 12 of the Declaration of John A. Houser, III, dated March 29, 1995, makes the conclusory assertion that "[d]uring that nearly two year period" between the onset of Ward's disability and the receipt by UNUM of notice, "UNUM was without knowledge that plaintiff claimed he was 'disabled' and was thereby deprived of the opportunity to fully evaluate his claim and to determine the extent of his disability at the time he claimed to be disabled," but offers no specific evidence showing how that evaluation has been impaired in this case. In fact, the Houser Declaration indicates that UNUM did not undertake to investigate, evaluate or determine Ward's claim on the merits, but assures that "[h]ad plaintiff timely filed his claim for disability benefits under the Policy, UNUM would have conducted a thorough claim investigation." Id. at P11 (emphasis added). On remand, UNUM has the burden to prove actual prejudice, that is, that Ward's delay would have prevented "a thorough claim investigation" in April of 1994 that otherwise would have been possible through November 5, 1993.



## IV

Ward addresses the timeliness of his claim in another way: he asserts that actual notice of his disability given to MAC as early as March of 1993 operates as notice to UNUM as early as March of 1993 because under California law, an employer who participates in the administration of a group insurance policy acts as an agent of the insurer. He relies on Elfstrom v. New York Life Ins. Co., 67 Cal. 2d 503, 432 P.2d 731, 63 Cal. Rptr. 35 (1967), as authority for this proposition. Ward further asserts that if the Elfstrom rule is somehow preempted by ERISA, this court should adopt a like rule as a matter of federal common law. Moreover, Ward asserts that MAC breached its duties as an ERISA co-fiduciary to inform him of the availability of long-term disability benefits under the UNUM policy, to receive notice of his claim, and to assist him in furnishing appropriate proof of his claim to UNUM, breaches which Ward contends UNUM was

obliged to remedy. See 29 U.S.C. § 1105(a) ("a fiduciary with respect to a plan shall be liable for a breach of fiudciary responsibility of another fiduciary with respect to the same plan in the following circumstances: . . . (3) if he has knowledge of a breach by such other fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach.").[5]

The Elfstrom Rule

In Elfstrom, the employer, Fullerton Publishing Co., had obtained a group life insurance policy for the benefit of its employees from the defendant, New York Life. The plaintiff was president and majority shareholder of Fullerton and the father of Brenda, the deceased employee, as well as the beneficiary under his daughter's life insurance certificate. Fullerton's bookkeeper, Mr. Still, administered the group policy under the direction of a New York Life group representative, following the directions set forth in a manual supplied by New York Life for that purpose. Mrs. Still mistakenly included Brenda as an insured in monthly reports to defendant insurer when, in fact, Brenda was not eligible, because her employment at the minimum salary required had terminated before expiration of the waiting period necessary for coverage. The premiums were paid until Brenda's death, seven months after expiration of the waiting period. Under these facts, the California Supreme Court held that the duties of the employer, discharged by Mrs. Still, in administering

[5] As Ward noted in his opening brief, whether an individual plan beneficiary may seek relief in his own behalf for breach of fiduciary duty under ERISA was raised in Varity Corp. v. Howe, 116 S. Ct. 1065 (1996). Varity answered that question in the affirmative, holding that plan participants and beneficiaries may sue for individual "appropriate equitable relief" pursuant to § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), and are not limited solely to relief in favor of the plan itself as in Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 144 (1985), construing ERISA § 502(a)(2). Id. at 1075-79.



the group life insurance policy, made it the agent of defendant insurer, and that the insurer was bound by the mistakes of the employer (per Mrs. Still) acting within the scope of the agency, provided the plaintiff (beneficiary) was acting in good faith in directing her to effect coverage for Brenda.

We are convinced that the employer is the agent of the insurer in performing the duties of administering group insurance policies. It cannot be said that the employer acts entirely for its own benefit or for the benefit of its employees in undertaking administrative functions. While a reduced premium may result if the employer relieves the insurer of these tasks . . . the insurer also enjoys significant advantages from the arrangement.

67 Cal. 2d at 512-13, 432 P.2d at 737. For the Elfstrom court, agency depended on the question of control:

The most persuasive rationale for adopting the view that the employer acts as the agent of the insurer . . . is that the employee has no knowledge or control over the employer's actions in handling the policy or its administration. An agency relationship is based upon consent by one person that another shall act in his behalf and be subject to his control. . . . It is clear from the evidence regarding procedural techniques here that the insurer-employer relationship meets this agency test with regard to the administration of the policy, whereas that between the employer and its employees fails to reflect true agency. The insurer directs the performance of the employer's administrative acts, and if these duties are not undertaken properly the insurer is in a position to exercise more constricted control over the employer's conduct.

67 Cal. 2d at 513-14, 432 P.2d at 738; see also Prudential Ins. Co. of America v. State Bd. of Equalization, 21 Cal. App. 4th 458, 482, 26 Cal. Rptr. 2d 287, 303 (1993) ("As expressed in Elfstrom, the agency relationship was shown by the insurer's control over the book-

keeper's performance of tasks relating to the insurance, i.e., the bookkeeper/agent performed functions under the insurer/principal's direction and for the principal's benefit.").

In reaching its conclusions regarding agency, Elfstrom cited this court's earlier decision in John Hancock Mut. Life Ins. Co. of Boston v. Dorman, 108 F.2d 220 (9th Cir. 1939). In John Hancock, Western Bakeries, the employer, "handled" the insurance under a group life/disability insurance master policy obtained for the benefit of employees; Western Bakeries had accepted insurance applications, determined employee eligibility, issued certificates of insurance, and collected premiums, all of which it then reported to the insurer. We held that the employer was the insurer's agent in handling these tasks and that acceptance of premiums by the insurer through its agent/employer estopped the insurer from claiming that the insured was not an employee within the meaning of the policy. 108 F.2d at 222-23, 224.

More recent California cases echo the Elfstrom/John Hancock rule. In McCormick v. Sentinel Life Ins. Co., 153 Cal. App. 3d 1030, 200 Cal. Rptr. 732 (1984), the California Court of Appeals explained:

In Elfstrom v. New York Life Ins. Co. (1967) 67 Cal.2d 503, 505, 63 Cal.Rptr. 35, 432 P.2d 731, our high court considered whether the acts of an employer who administered a group health insurance policy could be attributed to the defendant insurer. After reviewing conflicting cases from other jurisdictions, the court concluded the employer was acting as the insurer's agent and hence the insurer was liable for the employer's conduct. (Id., at p. 508, 63 Cal.Rptr. 35, 432 P.2d 731, citing Rest.2d Agency, §§ 165, 282(2), and pp. 512-513.) In rejecting the view the employer acted as the employee's agent, the court cited the employer's assumption of the insurer's administrative functions and the employee's lack of control over the employer's actions in handling the policy. (Id., at pp. 513-514, 63 Cal.Rptr. 35, 432 P.2d 731; accord Bareno v. Employers Life Ins. Co. (1972) 7 Cal. 3d 875, 883, 103 Cal.Rptr. 865, 500 P.2d 889; Pantzalas v. Superior Court (1969) 272 Cal.App.2d 499, 504, 77 Cal.Rptr. 354.)



Here, the credit union, like the employer in Elfstrom performed administrative duties in connection with processing claims under Sentinel's disability policy. It is undisputed the credit union assumed such responsibilities as maling the initial claim form to McCormick, notifying Sentinel of a possible claim from McCormick, and apprising McCormick his claim was incomplete. It also appears likely McCormick had no control over the credit union's actions. Under these circumstances a triable issue exists as to whether the credit union was acting as Sentinel's agent. If the fact finder determines an agency relationship, as defined in Elfstrom, did exist, the credit union's acts can be attributed to Sentinel.

153 Cal. App. 3d at 1040-41, 200 Cal. Rptr. at 737; see also Metropolitan Life Ins. Co. v. State Bd. of Equalization, 32 Cal. 3d 649, 658-59, 652 P.2d 426, 431, 186 Cal. Rptr. 578, 583 (1982) (Elfstrom is controlling on issue whether an employer acts as the insurer's agent in administering group insurance policies); Bass v. John Hancock Mutual Life Ins. Co., 10 Cal. 3d 792, 797, 518 P.2d 1147, 1150, 112 Cal. Rptr. 95, 198 (1974) ("[W]e have held that the employer is the agent of the insurer in performing the duties of administering group insurance policies . . . and that accordingly the insurer shares responsibility for the employer's mistakes."); Caldwell v. United Bus Corp., 77 Cal. App. 3d 381, 383-84, 112 Cal. Rptr. 7, 8 (1986) ("The general rule in California is that the employer is merely the agent of the insurer in performing the duties of administering group health insurance policies.").

Other jurisdictions as well have adopted a similar approach to the agency question. See, e.g., Middleton v. The Russell Group, Ltd., 483 S.E.2d 727, 734 (N.C. 1997) (holding that "[a]n employer who performs administrative functions [under a group insurance policy], as in the instant case, is deemed to be the agent of the insurer," (citing Elfstrom)), and cases cited therein; Abiatti v. Buttura & Sons, Inc., 161 Vt. 314, 324, 639 A.2d 988, 993-94 (1994) (agency relationship may be founded upon the policyholder's performance of administrative tasks on behalf of the insurer); Kirkpatrick v. Boston Mut. Life Ins. Co., 393 Mass. 640, 645-46, 473 N.E.2d 173, 176-77 (1985) ("Whether or not the employer acts as the insurer's agent is a factual question to be resolved on a case by case basis."); Norby v. Bankers Life Co. of Des Moines, Iowa, 304 Minn. 464, 471-72, 231 N.W.2d 665, 670 (1975) ("the employer policyholder may, in appropriate circumstances, be found to be the agent of the group insurer of employees").

In Paulson v. Western Life Ins. Co., 636 P.2d 935 (Or. 1981), the Oregon Supreme Court held that whether an employer acted as agent for an insurer in administering a group policy presented a triable issue of fact. The Paulson court read Elfstrom and other cases as applying a rule expressed in these terms: "In the performance of a function delegated by the insurer to the employer, the employer is deemed to be the agent of the insurer." 636 P.2d at 941.[6]

[6] Paulson rejected the view that the cases divide into a "majority rule" and a "minority rule" concerning the employer-agency question:

> Our analysis of the decisions convinces us that many courts, even though they purport to apply a "majority rule" or a "minority rule," actually base their decision upon the facts relating to the division of functions between the insurer and the employer policyholder, and that any "majority" or "minority" rule is more apparent than real. It is more correct to say that when the plan is exclusively administered by the insurer, as a matter of law no agency relation exists between the insurer and the employer. But if the employer performs all of the administration of the policy, an agency relationship exists between the insurer and the employer, as a matter of law. Between these two extremes, as the division of functions becomes less separate, or to put it another way, as the employer assumes responsibility for more administrative or sales functions which are customarily performed by an insurer, a question of fact will arise as to the agency relationship between the insurer and the employer.

636 P.2d at 939.

The Paulson formulation of the Elfstrom rule appears sound. It also comports with our prior determination of the same issue in John Hancock.



MAC's Administration of the UNUM Policy

Central to Ward's agency theory under Elfstrom must be proof that MAC participated in the administration of UNUM's group disability insurance policy and performed insurance-related tasks delegated by or carried on under the direction and ultimate control of UNUM. Ward points to the fact that MAC was designated as plan administrator by the MAC Plan as well as to specific provisions of the UNUM policy (Sec. VI, P D) requiring MAC to furnish information to UNUM concerning employees who become eligible for coverage, whose coverage changes in amount, or whose coverage terminates.

Arguing that courts must follow an "absolute and literal interpretation" [7] of the language of ERISA plan docu-

[7] For this proposition, UNUM cites Madden v. ITT Long Term Disability Plan, 914 F.2d 1279, 1285-86 (9th Cir. 1990), cert. denied, 498 U.S. 1087 (1991). Headnote no. 7 of the Madden opinion recites that "[f]iduciary's delegate properly gave absolute and literal interpretation to long-term disability plan's definition of 'total disability', which required that employee was unable to engage in any occupation," but this synopsis does not accurately reflect the relevant portion of the Madden opinion. What we said was "Metropolitan's use of the Plan definition was clearly proper, because as an ERISA fiduciary, Metropolitan was required to apply the terms

ments, UNUM points to Section VI, Paragraph L of its long-term disability policy, which reads:

L. AGENCY

For all purposes of this policy, the policyholder acts on its own behalf or as agent of the employee. Under no circumstances will the policyholder be deemed the agent of the Company without a written authorization.

Averring that no such written authorization was ever issued to MAC, and "MAC's involvement in the LTD [long-term disability] claims process was, at most, acting as a conduit between MAC employees and UNUM," UNUM urges the conclusion that "MAC is not UNUM's agent."

Of course, the existence of an agency relationship generally presents a question of fact:

> Whether as between the parties their relationship is one of agency depends on their relations as they in fact exist under the agreement or acts of the parties, and the question is not governed by the stipulations of the parties.

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of the Plan. See ERISA, 29 U.S.C. § 1104(a)(1)(D) (1988)." 914 F.2d at 1286 n.6.

While this court has more recently admonished that "[a]n ERISA plan administrator abuses its discretion if it construes provisions of plan in a way that 'conflicts with plain language of plan,'" Saffle v. Sierra Pacific Power Co. Bargaining Unit Long Term Disability Income Plan, 85 F.3d 455, 458 (9th Cir. 1996) (quoting Taft v. Equitable Life Assur. Soc'y, 9 F.3d 1469, 1472 (9th Cir. 1993)), we have yet to endorse a rule of strict, absolute or literal construction of ERISA plan documents. Indeed, Saffle appears to reject a "literal" construction of plan language in favor of a "reasonable" one, consistent with case law from other circuits. See id. at 458-59 (citing Helms v. Monsanto Co., Inc., 728 F.2d 1416, 1420 (11th Cir. 1984) (rejecting arbitrator's "absolute and literal" interpretation of "totally and permanently disabled" to mean complete helplessness as unreasonable because it would render the entire plan meaningless and would contradict policies underlying ERISA); Torix v. Ball Corp., 862 F.2d 1428 (10th Cir. 1988) (same)).



> Thus, whether a particular relationship is that of agency does not depend on what the parties call it, and the parties cannot, where the relationship is in fact one of agency, change its nature by declaring that it is not an agency, nor can they, by calling their relations one of agency, make it so when it is not so in fact. The surrounding facts and circumstances determine the relationship, regardless of the understanding of the parties as to the exact nature of the relationship. . . .
>
> 2A C.J.S. Agency § 7 (1972) (footnotes omitted); accord, Wallace v. Sinclair, 114 Cal. App. 2d 220, 250 P.2d 154, 16061 (1953); American Marine Paint Co. v. Nyno Line, 70 Cal. App. 415, 233 P. 366, 369 (1924) ("nor does it matter whether or not his employment be called an agency"); 3 Am. Jur. 2d Agency § 21 (1986) ("The manner in which the parties designate the relationship is not controlling, and if an act done by one person in behalf of another is in its essential nature one of agency, the one is the agent of such other notwithstanding he is not so called." (footnote omitted)); 2 (pt. 2) Cal. Jur. 3d Agency § 12, at 170-73 & nn. 77-93 (1997) (citing Elfstrom). Ordinarily, an agency relationship may be established through evidence of control and apparent or applied authority, even where the parties have agreed to the contrary. See, e.g., Kuchta v. Allied Builders Corp., 21 Cal. App. 3d 541, 547, 98 Cal. Rptr. 588, 591 (1971) (notwithstanding that "the agreement itself stated that no such agency relationship was created, the declarations of the parties in the agreement respecting the nature of the relationship are not controlling."); Fernander v. Thigpen, 278 S.C. 140, 293 S.E.2d 424, 426 (1982).

However, UNUM also asserts that ERISA preempts the Elfstrom rule because Elfstrom imposes respondeat superior liability; according to UNUM, "ERISA's rule of personal fiduciary liability not only supersedes, but is inconsistent with, the doctrines of respondeat superior and

vicarious liability." Nor could the Elfstrom rule be adopted as a matter of federal common law because adoption of respondeat superior and vicarious theories would impermissibly "revise the text" of ERISA by adding causes of action or remedies not affirmatively authorized by the statute. See Mertens v. Hewitt Assoc., 508 U.S. 248, 259 (1993) ("The authority of courts to develop a 'federal common law' under ERISA . . . is not the authority to revise the text of the statute.").

No prior Ninth Circuit opinion has addressed the relationship of ERISA to state agency law,[8] or more specifically, whether ERISA preempts the rule of California state law announced in Elfstrom. Nor has any prior opinion of this court discussed whether under circumstances such as these, federal statutory or common law creates the agency relationship that Ward suggests.

Looking to case law from other circuits, Turrill v. Life Ins. Co. of North America, 753 F.2d 1322 (5th Cir. 1985), informs our inquiry. Turrill, an American Airlines facility maintenance mechanic, became disabled after a fall on a wet floor at the Dallas/Ft. Worth airport. The insurer had issued a group disability insurance policy to American Airlines that was in effect at the time of the accident. Turrill did not submit notice or proof of his claim directly to the insurer until more than two years after the accident. However, soon after the accident, he did submit an array of documentation concerning his injury to his employer. Reversing summary judgment in favor of the insurer on grounds of timeliness, the Fifth Circuit concluded that "a genuine issue of material fact

[8] We have noted, however, that Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 318 (1992), "construed the term 'employee' in the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.S 1002(6), as incorporating 'judicial agency law criteria for identifying master-servant relationships.' Id. at 319 . . . ." Coupar v. United States Department of Labor, 105 F.3d 1263, 1266-67 (9th Cir. 1997).



exists regarding the authority of American Airlines to receive proofs of loss" as an agent of the insurer. Id. at 1324. "Whether such an agency relationship existed bears heavily on the timeliness of Turrill's proof of loss. . . ." Id.

To resolve the agency question, the Turrill court looked both to Texas agency law and to ERISA.

Under the Employee Retirement Income Security Act of 1974 (ERISA), . . ., an employer who, like American Airlines, provides disability benefits through a group insurance policy owes fiduciary duties to the participating employees and their beneficiaries. See 29 U.S.C. § 1104 (a)(1) (1982) ("[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and the beneficiaries.") The fiduciary obligations of such an employer easily include responsibility to take care that the insurance company receives documentation necessary under the group policy to achieve recovery on a just benefits claim. This is especially so if the documentation is already in the agent's hands.

ERISA thus obliged American Airlines to exercise care and diligence in assuring compliance with the proof of loss requirements of the master policy. It also required the employer to provide to participating employees extensive information regarding the plan. 29 U.S.C. § 1021 (1982).

ERISA compels the employer (or other plan fiduciary) to act affirmatively in administering and providing information on its employee benefits plan. In cases involving group policies, the requisite employer's efforts include determining employees' eligibility for coverage, enrolling them in the plan and group policy, advising them as to scope of benefits, collecting and forwarding premiums, and helping employees file claims. An insurance company normally performs these functions. But in group insurance

situations where ERISA applies, the employer and group insurer typically develop a course of dealing in which the employer substitutes for the insurer in a relationship that ERISA impliedly may require.

Under these circumstances, courts may properly infer an agency relationship. The group insurer's failure to disavow the sufficiency of the employer's performance of functions that ERISA requires the employer to perform can properly lead to a conclusion that the group insurer is representing that an agency relationship exists as to those functions. . . .

Id. at 1325 (footnote & citation omitted). The Turrill court held that "proof of an employer's ERISA-based reporting and fiduciary responsibilities with respect to a group insurance policy in itself raises an issue under Texas law as to the existence of an agency relationship between the employer and the group insurer." Id. Nothing in Turrill even hints that state agency law is somehow preempted by ERISA.

MAC's Fiduciary Duties Under ERISA

In enacting ERISA, Congress did not explicitly enumerate all the duties of an ERISA fiduciary, and did not describe every instance in which an employer acts in a fiduciary capacity, but intentionally left many of these details for the courts to develop in light of the special nature and purpose of employee benefit plans. Varity Corp. v. Howe, 116 S. Ct. 1065, 1070 (1996). ERISA contemplates that an employer often will act as both employer and plan fiduciary, but not all of the employer's business activities implicate ERISA's fiduciary duties. Id. at 1071.

At minimum, ERISA makes an employer who exercises "discretionary authority or discretionary responsibility" in plan administration a fiduciary:



> [A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets . . . or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A). An employer who performs "purely ministerial functions" in administering a plan may not be a fiduciary, but even so, "[t]he issue is not just how the duties are characterized, but what they are." IT Corp. v. General American Life Ins. Co., 107 F.3d 1415, 1419 (9th Cir. 1997); see also 29 C.F.R. § 2509.75-8, at D-2 (1996) ("[P]ersons who have no power to make any decisions as to plan policy, interpretations, practices or procedures" are not fiduciaries under ERISA).

In this case, MAC's activities as plan administrator included determining employees' eligibility for coverage, enrolling them in the plan, issuing certificates of insurance under the group policy, advising employees as to scope of benefits, collecting and forwarding premiums to UNUM, and on occasion, at least, helping employees file claims. In addition, the certificate of coverage and summary plan description pamphlet prepared by UNUM and distributed to MAC employees by MAC advises employees that MAC is the Plan Administrator, that "[t]he people who operate your Plan, called 'fiduciaries' of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries," and instructs employees that "[i]f you have any questions about your Plan, you should contact the Plan Administrator." [9]

Arguably, MAC has assumed fiduciary duties under ERISA in the administration of the MAC Plan.[10] Consis-

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[9] UNUM's certificate of coverage also counsels employees that "[i]f you have any questions about any terms and provisions, please contact the Insurance Administrator at your work location or write to our claims paying office."

tent with Turrill, proof of MAC's fiduciary duties under ERISA with respect to UNUM's group insurance policy raises an issue under California law as to the existence of an agency relationship between the employer and the group insurer in light of Elfstrom.

ERISA Preemption

Within its reach, ERISA regulates plans which provide employees with pension and welfare benefits. "It is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." Burgio and Campofelice, Inc. v. New York State Dep't of Labor, 107 F.3d 1000, 1007 (2d Cir. 1997). Section 514(a) of ERISA promotes uniform federal regulation of employee benefit plans by preempting "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA, subject to limited exceptions. 29 U.S.C. § 1144(a). Section 514(a)'s purpose "was to minimize the administrative and financial burden of complying with conflicting directives among States and between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990).

While § 514(a)'s language is "deliberately expansive," Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 46 (1987), ERISA does not preempt "if the state law has only a 'tenuous, remote, or peripheral' connection with covered plans, . . . as is the case with many laws of general applicability. . . ." District of Columbia v. Greater Washington Bd. of Trade, 506 U.S. 125, 130 n.1 (1992) (quoting Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100 n.21 (1983)). In fields of traditional state regulation, ERISA preempts

[10] The term "fiduciary" has a broader meaning under ERISA than at common law because ERISA "defines 'fiduciary' not in terms of formal trusteeship, but in functional terms of control and authority over the plan." Mertens, 508 U.S. at 262.



state law if that is " 'the clear and manifest purpose of Congress.' " New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995) (quoting Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947)). The Supreme Court recently acknowledged the existenc eof "myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." California Div. of Labor Standards Enforcement v. Dillingham Constr., 117 S. Ct. 832, 842 (1997).

In each instance, the intent of Congress controls our analysis of preemption under ERISA. Yet the statute itself offers little guidance as to when a state law "relates to" an ERISA plan within the meaning of § 514(a). In the Travelers case, the Supreme Court observed that courts "must simply go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." 514 U.S. at 656. In light of legislative history indicating that "the basic thrust of the preemption cause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans," the Travelers Court concluded that two types of state laws "relate to" employee benefit plans within § 514(a): laws that "mandat[e] employee benefit structures or their administration," and laws that "provid[e] alternative enforcement mechanisms." Id. at 657-58.

ERISA and Elfstrom

ERISA and Elfstrom are not anathema. Elfstrom does not dictate the benefits to be provided or the manner in which the plan will be administered. Elfstrom does not require an employer to participate in the administration of a group insurance policy or an insurer to delegate its functions to an employer.[11] Nor does Elfstrom create an

[11] In this case "California is not telling employers how to write their ERISA plans. Nor is it conditioning some requirement on

"alternate enforcement mechanism" for ERISA plan obligations beyond those set forth in the statute. Contrast Pilot Life, 481 U.S. at 55-57. Elfstrom simply describes in legal terms a relationship that already exists in fact.

As Turrill illustrates, the principle that an employer who undertakes responsibilities in administering an employee benefit plan assumes fiduciary duties under ERISA meshes smoothly with the Elfstrom rule that an employer who assumes such responsibilities in administering a group insurance policy acts as the agent of the insurer. Turrill, 753 F.2d at 1324-25; see also Middleton, 483 S.E.2d at 732-35 (on claim for unpaid benefits under ERISA § 502, Elfstrom rule applies to hold insurer accountable for employer's mistake in denying former employee COBRA continuation coverage; other state law claims preempted by ERISA).

Ostensibly, the legislative effort was to ensure that employee benefits are provided through an ERISA plan overseen by plan fiduciaries, including the plan insurer and those who the insurer may enlist to participate in the administration of the plan. Nothing in § 514(a) empowers a plan fiduciary to extend ERISA's preemptive reach by using policy language that negates agency law principles in favor of exonerating itself from the errors of those who act on its behalf. Cf. IT Corp., 107 F.3d at 1418 (any interpretation of a plan which prevents a plan fiduciary from being held liable as a fiduciary is void); 29 U.S.C. § 1110(a). Plan documents defining or disavowing a relationship do not have the status of the ERISA statute, particularly when the actions of the signators belie the document recitals.[12]

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how individual employers write their ERISA plans." WSB Elec., Inc. v. Curry, 88 F.3d 788, 796 (9th Cir. 1996); see Employee Staffing Services, Inc. v. Aubry, 20 F.3d 1038, 1041 (9th Cir. 1994).

[12] Merely reciting that "if the terms of your certificate of coverage and the policy differ, the policy will govern" does not resolve the question. Where the certificate remains silent on the subject of agency, the existence in fact of an agency relationship does not constitute a "term" of the certificate.

Whether an agent or not, if an employer/plan administrator exercises sufficient authority over the plan to become an ERISA fiduciary, contractual policy disclaimers could not limit fiduciary and co-fiduciary liability under ERISA. See IT Corp., 107 F.3d at 1418-19.



Even if UNUM could by agreement with MAC exonerate itself of its agency relationship as against MAC, there is no reason to suppose that the agreement would exonerate UNUM from its duties to participants and beneficiaries of the ERISA plan, or the conduct of those who act on its behalf with apparent authority. The employee participants did not sign the agreement bearing the agency disclaimer and they are entitled to have the plan administered in the interest of participants and beneficiaries. See 29 U.S.C. § 1104. Absent the insurer's over disavowal of the sufficiency of the employer's performance of functions under the plan, actually communicated, the participants and beneficiaries should be able to rely upon the relationships that exist. Nothing in ERISA suggests that in availing themselves of plan benefits, employee participants must sift plan documents for hidden disclaimers that the designated plan administrator does not act as agent for the plan or its insurer.[13] The statute must do more than set traps for the unwary.

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[13] UNUM cites Kennedy v. System One Holdings, Inc., 835 F. Supp. 947 (S.D. Tex. 1993), as rejecting a participant's claim that UNUM was estopped from denying his late claim based upon misrepresentations by the employer/plan administrator because, inter alia, "the Plan clearly and unambiguously provides that System One is not UNUM's agent . . . ." Id. at 951 (footnote omitted). Kennedy relies on policy language essentially identical to Section VI, Paragraph L of the long-term disability policy issued to MAC. See id. at 951 n.5. However, Kennedy does not discuss Turrill, and nothing in Kennedy suggests that the plaintiff gave his employer timely notice of his disability claim, or even that the employer had undertaken administrative responsibilities under the insurance policy in question. In fact, Kennedy identifies UNUM—not the em-

Applied in the context of this case, Elfstrom does not operate to create a cause of action against UNUM outside of the exclusive claim for unpaid benefits pursuant to § 502(a) of ERISA, 29 U.S.C. § 1132(a), pleaded in Ward's complaint. Contrast Kanne v. Connecticut Gen. Life Ins. Co., 867 F.2d 489, 494-95 (9th Cir. 1988) (state statutory claim for delayed benefits payment preempted by ERISA); Perkins v. Time Ins. Co., 898 F.2d 470, 474 (5th Cir. 1990) (state law tortious breach of contract and bad faith claims against insurer for nonpayment of benefits preempted by ERISA). Nor does Elfstrom alter the facts as between MAC and UNUM, or create an agency relationship that may or may not exist as a consequence of the parties' own course of dealing. The question ultimately for the district court under Elfstrom becomes whether MAC acted for UNUM and under UNUM's control in receiving and forwarding long-term disability claims, and thus whether timely notice to MAC of Ward's disability operated as timely notice to UNUM as well.

In the context of a claim for unpaid benefits under § 502(a), ERISA does not operate to preempt the application of the state law embodied in Elfstrom and its progeny to determine the question of timeliness of notice and proof of claim. We are not persuaded that Congress had as its clear and manifest purpose the abrogation of state agency law as it applies to insurers and employers administering group insurance policies.

Whether MAC acted as fiduciary and as agent of UNUM in administering the MAC Plan's long-term disability policy, particularly in receiving and forwarding

ployer—"as administrator of the long term disability benefits plan at issue in this case." Id. at 949; see also id. at 948 (plaintiff sought benefits under "an employee welfare benefit plan ('Plan') administered by UNUM"). Thus, Kennedy does not address the Elfstrom rule because the issue was not raised in that case.

Indeed, we could identify no reported case giving the effect to this language now urged by UNUM.



claims for benefits,[14] cannot be decided as a matter of law on the existing record. The questions of employer-insurer agency and employer fiduciary duty instead raise genuine issues of fact.[15]

However, these issues become material in this case only if the question of timeliness of submission of proof of claim to UNUM, including actual prejudice under Cisneros, is ultimately resolved adversely to Ward.

The judgment of the district court is REVERSED and the case is REMANDED to the district court with instructions to remand to the plan administrator for a determination as to whether UNUM suffered actual prejudice by reason of the delay in submission of Ward's notice of claim, and if necessary following remand to the plan administrator, to determine whether MAC acted as ERISA fiduciary and as agent of UNUM in administering the MAC Plan's long-term disability policy, particularly in receiving and forwarding claims for benefits, and if so, whether Ward furnished timely notice and proof of his disability to MAC, and if so, to what remedies Ward may be entitled.

[14] See Norby, 304 Minn. at 472, 231 N.W.2d at 670 ("The focus . . . should be on which specific and relevant administrative functions are performed by the employer on behalf of the insurer, with respect to the particular ground asserted for . . . nonpayment under the policy. . . . An employer may be considered an agent of an insurer for some purposes but not for others.")

[15] The extent of UNUM's liability, if any, for breach by a cofiduciary pursuant to 29 U.S.C. § 1105(a) depends, inter alia, on UNUM's knowledge of the breach, which raises even more issues of fact. That MAC has not been joined as a party to this litigation does not impair Ward's entitlement to relief under ERISA § 502(a)(1), but may raise procedural questions as to any further relief sought under § 502(a)(3). Cf. Madden, 914 F.2d at 1287 (" 'ERISA permits suits to recover benefits only against the Plan as an entity, . . . and suits for breach of fiduciary duty only against the fiduciary.' " (quoting Gelardi v. Pertec Computer Corp., 761 F.2d 1323, 1324-25 (9th Cir. 1985) (citations omitted)).

Moreover, to the extent that Ward may be entitled to receive payment of benefits pursuant to ERISA § 502(a)(1), further equitable relief under § 502(a)(3) may not be "appropriate." Varity Corp., 116 S. Ct. at 1079.

[Filed Mar. 23, 1998]

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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No. 95-56269
D.C. No. CV-94-01454-MHH

JOHN E. WARD,
*Plaintiff-Appellant,*
v.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN (proper party name) UNUM Life Insurance Company of America,
*Defendant-Appellee.*

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Before: FLETCHER and TROTT, Circuit Judges, and JENKINS,* District Judge

ORDER

The panel has voted to deny the petition for rehearing. Judges Fletcher and Trott vote to reject the suggestion for rehearing en banc and Judge Jenkins so recommends.

The full court has been advised of the suggestion for an en banc rehearing, and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35.

The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

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* Honorable Bruce S. Jenkins, United States District Judge for the District of Utah, sitting by designation.



[Filed Aug. 8, 1995]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

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Case No. CV 94-1454 H(AJB)

JOHN E. WARD,
*Plaintiff,*
vs.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN,
*Defendant.*

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ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

Defendant UNUM has filed a motion for summary judgment. Plaintiff opposes the motion. On August 3, 1995, the court held a telephone oral argument in this matter and both parties assented to having the matter heard on this date. Brooks Iler appeared on behalf of plaintiff John Ward and Jeffrey Smith appeared on behalf of defendant UNUM.

Having reviewed the papers submitted in this matter and having heard oral argument in the case, the court grants defendant's motion for summary judgment.

BACKGROUND

Plaintiff was the former Chief Executive Officer of Management Analysis Company ("MAC"). On May 8, 1992, plaintiff resigned from his position upon the request of the company's Board of Directors over financial concerns about a particular company project.

Throughout his nine years of employment with MAC, plaintiff had premiums for long-term disability insurance deducted from his paycheck. The disability policy is an insured employee welfare benefit plan called the Management Analysis Company Plan (the "Plan") and is issued by UNUM Life Insurance Company of America ("UNUM").

The issue in this case is whether plaintiff made a timely claim for benefits under the Plan. According to plaintiff's application for benefits, he first became aware of his disability on May 5, 1992. In December 1992, plaintiff received a diagnosis of diabetic neuropathy.

Following confirmation of his diagnosis, plaintiff filed a claim for state disability benefits. In or around late February or early March 1993, plaintiff received notice that his state benefits application had been approved. Plaintiff then contacted the Human Resources division of MAC to arrange for the continuation of his insurance coverage under COBRA. The company's Administrative Vice-President, Dexana MacQuarrie, forwarded materials regarding COBRA benefits to plaintiff and explained that plaintiff needed to get a disability determination from the Social Security Administration in order to extend his insurance benefits.

In July 1993, plaintiff received his Social Security award of disability, a copy of which he forwarded to MAC's Human Resources department. At that time, neither Maria Bonney, the employee handling plaintiff's health insurance coverage, nor Dexana MacQuarrie mentioned to plaintiff that he might obtain coverage under the Plan.

In April 1994, while cleaning out a safety deposit box, plaintiff discovered a booklet entitled "Your Long Term Disability Income Benefits." Upon discovering the pamphlet, plaintiff contacted Maria Bonney to determine whether he was covered under the long-term plan. Bonney told plaintiff that he was indeed covered and sent



him an application for long term disability benefits. Under the terms of the Plan, if plaintiff's claim had been approved, he would have been entitled to $13,000 per month for a period of forty-two months which adds up to a total available benefit of approximately $546,000.

Plaintiff completed the application and submitted it to MAC. MAC completed the employer section and forwarded the application to UNUM on April 11, 1994.

On April 13, 1994, UNUM advised plaintiff that his claim would not be reviewed because it was not submitted in a timely fashion. On June 6, 1994, plaintiff's counsel requested a review of UNUM's claim denial. Six days later, UNUM confirmed its denial of coverage. Plaintiff then filed this suit in federal court.

On May 8, 1995, the court denied without prejudice defendant's motion for summary judgment noting that there were unresolved material issues of fact in regards to the agency issue.

## DISCUSSION

### A. *Standard*

A motion for summary judgment shall be granted where "there is no genuine issue as to any material fact and . . . the moving party is entitled to judgment as a matter of law." FED R. CIV P. 56(c); *British Airways Bd. v. Boeing Co.*, 585 F.2d 946, 951 (9th Cir. 1978). Any doubt as to the existence of any issue of material fact requires denial of the motion. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986). The opposing party cannot rest on the mere allegations or denials of his pleading, but must "go beyond the pleadings and by her own affidavits, or by the 'depositions, answers to interrogatories, and admissions on file' designate 'specific facts showing that there is a genuine issue for trial.'" *Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986) (citation omitted).

B. *Application of Standard*

1. *Application of Agency Standard*

Defendant argues that as a matter of law it was not required to entertain plaintiff's application for long-term disability benefits because the application was untimely. Plaintiff argues that he provided timely notice to his employer, MAC, and that under agency law, timely notice to MAC was tantamount to timely notice to UNUM.

First, the court considers the issue of whether agency law is applicable to this case. The MAC plan administered by UNUM is governed by ERISA and ERISA preempts all state law claims "relating to" an ERISA plan. 29 U.S.C. § 1144(a); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987). Plaintiff argues however, that in this instance, state agency law applies. Specifically, plaintiff relies upon *Elfstrom v. New York Life Ins. Co.*, 67 Cal.2d 503 (1967). In *Elfstrom*, the California Supreme Court concluded that where an employer is the named insured under a group insurance policy, the employer acts as an agent of the insured. *Id.* at 513. In reaching this conclusion, the court noted that in performing administrative duties related to the group insurance benefits, the employer was not acting entirely for its own benefit, but for the benefit of both the insurance company and itself. *Id.* at 511. Administrative duties included determination of employee's eligibility for insurance and completing the certificate of insurance. *Id.* at 513-14.

Plaintiff contends that his employer furnished UNUM with information regarding MAC's employees, determined which employees were eligible for coverage and arranged for payments to be made to UNUM. By performing these duties, plaintiff suggests that MAC acted as an agent for UNUM. As such, plaintiff argues that providing notice to the human resources division of MAC constituted timely notice to UNUM.



Defendant contends that in this case, the holding in *Elfstrom* is not applicable because ERISA preempts the field. Plaintiff argues that under the "savings clause," ERISA does not preempt "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). To determine whether a state provision falls under the "savings clause," the court must determine if the state provision is specifically directed to the insurance industry. *Pilot Life*, 481 U.S. at 48. Whether the law affects the "business of insurance" is further determined by a three-prong test: (1) whether the practice has the effect of spreading a policyholder's risk; (2) whether it is an integral part of the policy relationship between insurer and insured; and (3) whether it is limited to entities within the insurance industry. *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 739 (1985).

Here, the court notes that *Elfstrom* does not meet all the necessary criteria. First, the mere fact that an employer acts as an agent for the insurer does not transfer the policyholder's risk. The assumption of administrative duties by the employer does not transfer risk of loss from the insurer to the employer.

Second, the rule in *Elfstrom* is not an integral part of the policy relationship between insurer and insured. As defendant correctly points out, California law allows for limitations to be placed on an agency relationship between employer and insured. Specifically, California Insurance Code § 10209(d) states that "[t]he contract of insurance and individual certificate may contain provisions defining the extent to which the employer acts as the agent of the employee or may act as the agent of the insurer." *Id.* The policy in question here states that MAC "acts on its own behalf or as agent of the employee." It further states that "[u]nder no circumstances will [MAC] be deemed the agent of [UNUM] without a written authorization."

2. *Was Plaintiff's Application for Benefits Timely*

Because *Elfstrom* does not fall under the savings clause exception, the court finds that ERISA controls this case. Under ERISA, the district court reviews de novo a determination of non-eligibility for ERISA benefits. *Patterson v. Hughes Aircraft Co.*, 11 F.3d 948 (9th Cir. 1993). Terms in an ERISA insurance policy are interpreted in "an ordinary and popular sense as would a [person] of average intelligence and experience." *Evans v. Safeco Life Ins.*, 916 F.2d 1437, 1441 (9th Cir. 1991) (per curiam). Courts should not "artificially create ambiguity where none exists." *Id.* Finally, "[i]f a reasonable interpretation favors the insurer and any other interpretation would be strained, no compulsion exists to torture or twist the language of the policy." *Id.*

Under the terms of the Plan, plaintiff had 180 days from the discovery of his disability to file for long-term disability benefits. If it was not reasonable for him to give proof of disability within those 180 days, plaintiff was required to file his claim within one year plus 180 days from the onset of his disability. The policy regarding proof of claim was included in the booklet summarizing benefits which plaintiff found in his safe deposit box.

In his application for benefits, plaintiff states that his disability began on or about May 5, 1992. As such, the latest day for plaintiff to file his claim was December 5, 1993. However, plaintiff did not file his claim until April 11, 1994. Pursuant to the policy, plaintiff's claim was late and therefore defendant was not obligated to honor plaintiff's claim for long-term disability benefits.

Plaintiff claims he relied on MAC's human resources division to provide him with information regarding his benefits. The court notes, however, that plaintiff was not a mere employee of MAC, but served as CEO of the company. As CEO of the company, plaintiff met annually with the company's Human Resources department to review MAC's insurance plan, including the one at issue. Plaintiff states that five months before his termination, he attended a company-wide meeting relating to MAC's benefits. A UNUM representative provided information at that meeting. Thus, the court finds that plaintiff had adequate notice of the types of insurance coverage offered by his company.



Finally, as a point of policy, UNUM aptly notes that the reason for placing a time limit on filing proof of claims is to avoid the prejudicial effect of delay. The Plan extends only to a disability which occurred while plaintiff was working for the company. The delay in filing precludes UNUM from definitively determining whether plaintiff's disability existed on the date alleged in his claim.

## CONCLUSION

The court certainly finds the facts of this case to be sympathetic. Nonetheless, having carefully reviewed the matter, the court finds that plaintiff did not file a timely application for benefits. Accordingly, defendant's motion for summary judgment is granted.

IT IS SO ORDERED.

Dated: 8-7-95

/s/ Marilyn L. Huff
MARILYN L. HUFF
Judge
United States District Court

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

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Case No. 94-1454 H(AJB)

JOHN E. WARD,

*Plaintiff,*

vs.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN,

*Defendant.*

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Date: July 24, 1995
Courtroom of the Honorable Marilyn L. Huff

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DECLARATION OF JOHN A. HOUSER, III

Attached hereto for the Court's convenience is a true and correct copy of the Declaration of John A. Houser III, and the exhibits attached thereto. The original Declaration of Mr. Houser was filed in connection with Defendants' prior Motion for Summary Judgment and is contained in the Court's file.

DATED: June 26, 1995

Respectfully submitted,

JEFFREY P. SMITH
DAVID RIBAKOFF
ADAMS, DUQUE & HAZELTINE

By /s/ Jeffrey P. Smith
JEFFREY P. SMITH
Attorneys for Defendants
UNUM Life Insurance
Company of America and
Management Analysis
Company Plan



UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

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Case No. 94-1454 H(AJB)

JOHN E. WARD,

*Plaintiff,*

vs.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN,

*Defendant.*

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Date: May 8, 1995
Courtroom of the Honorable Marilyn L. Huff

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DECLARATION OF JOHN A. HOUSER, III

I, John A. Houser, III, declare as follows:

1. I am the Director-Technical Services in the Quality Review Section of UNUM Life Insurance Company of America ("UNUM"). The Quality Review Section is responsible for performing ERISA reviews of disability benefits claims such as that of John E. Ward, the plaintiff in this case.

2. The facts set forth herein are based upon my own personal knowledge. My personal knowledge is in part derived from my review of and familiarity with UNUM's records relating to this claim and the subject Group Policy No. 310727 (the "Policy"). Those records are business records of UNUM which were prepared by or received by employees of UNUM in the course of its business at or near the time of the acts, conditions or events described in the records. The records are prepared by persons with

knowledge or from information given by a person with knowledge of the acts, conditions, or events described in the records. The records are kept by UNUM in the course of its regularly conducted business activities, in accordance with its regular practices, and are trustworthy. If called as a witness in this matter, I could and would testify competently thereto.

3. Attached hereto as Exhibit 1 is a true and correct copy of the Group Long Term Disability Policy issued by UNUM Life Insurance Company of America to Management Analysis Corporation ("MAC") under which eligible employees of MAC were covered, including Mr. Ward. This is the Policy which was in effect on May 8, 1992, the date of Mr. Ward's alleged disability. The original effective date of the Policy was November 1, 1993.

4. Attached as Exhibit 2 is a true and correct copy of the employee certificate booklet which summarizes and describes the coverage under the Policy. This is the booklet which was in effect at the time of Mr. Ward's alleged disability. A quantity of these booklets were sent by UNUM to MAC for distribution to MAC's employees.

5. In accordance with terms the Policy, the policyholder (MAC) acts on its own behalf or as agent of the employee. Under no circumstances will the policyholder (MAC) be deemed the agent of the Company (UNUM) without a written authorization. [See, Policy at L-GPP-4] No such written authorization was ever issued by UNUM to MAC.

6. The Policy requires insureds to submit proof of their claims no later than 90 days after the end of the elimination period [Policy at L-GPP-2-L-GPP-3]. "Proof of claim" requires completion of a three part claim form. The first part, to be completed by the insured, is entitled "Application for Long Term Disability Benefits." The second part, to be completed by the employer/policyholder, is entitled "Employer's Report of Claim," and the



third part, entitled "Attending Physician's Statement" is to be completed by the insured's treating physicians.

7. On April 11, 1994, UNUM, through its Western Regional Benefits Office located in Glendale, California, first received notice of Mr. Ward's claim for long term disability benefits under the Policy. UNUM received the following documents pertaining to Mr. Ward's claim, true and correct copies of which are attached hereto:

a. A Long Term Disability Claim Employer's Statement, dated April 6, 1994 [Exhibit 3];

b. A Long Term Disability Claim Job Analysis dated April 6, 1994 [Exhibit 4];

c. Long Term Disability Claim Employee's Authorization dated March 29, 1994 [Exhibit 5];

d. Long Term Disability Claim Employee's Statement dated March 29, 1994 [Exhibit 6];

e. Letter from Maria Bonney dated April 6, 1994 [Exhibit 7];

f. W-2 Wage and Tax Statements 1991 and 1992 for John E. Ward [Exhibit 8];

g. Group Enrollment Request Card of John E. Ward [Exhibit 9];

h. Memorandum from MAC to John E. Ward dated April 5, 1983 Re: Statement of Insurance Coverage Effective Date: 3/21/83 [Exhibit 10];

i. Resume of John E. Ward [Exhibit 11];

j. Award Certificate Letter from Social Security Administration to John E. Ward, dated July 30, 1993 [Exhibit 12];

k. Long Term Disability Claim Physicians Statement of Robert A. Smith dated March 23, 1994 [Exhibit 13];

l. Letter from Christian W. Mende, M.D., F.A.C.P. to Whom it May Concern, dated March 28, 1994 [Exhibit 14];

m. Letter from N.A. Nabavi M.D., F.A.C.S. to Whom it May Concern, dated May 7, 1993 [Exhibit 15];

n. Letter from George A. Curry, II, M.D. to Robert A. Smith, M.D., dated March 24, 1994 entitled Supplemental Report [Exhibit 16];

o. Letter of John E. Ward to Western Regional Benefits, dated March 25, 1994, and accompanying list of attachments [Exhibit 17];

p. Letter of Robert A. Smith, M.D. to Department of Health and Human Services dated April 22, 1993 [Exhibit 18];

q. Radiology Report of David Rabinov, M.D., dated October 29, 1992 [Exhibit 19];

r. Letter of Magid Molaire, M.D. to Nicholas A. Nabari, M.D., dated November 16, 1992 [Exhibit 20];

s. Letter of Magid Molaire, M.D. to Nicholas A. Nabari, M.D., dated November 20, 1992 [Exhibit 21];

t. Letter of N.A. Nabavi, M.D. F.A.C.S. to Robert Smith, M.D. dated November 9, 1992, and enclosures [Exhibit 22];

u. Letter of Donald J. Sage, M.D., F.A.C.S. to Robert Smith, M.D., dated November 30, 1992 [Exhibit 23];

v. Letter of George A. Carey, II, M.D. to Robert A. Smith, M.D., dated April 15, 1993 [Exhibit 24].

8. Prior to the receipt of the aforementioned documents on April 11, 1994, UNUM had no notice or knowledge that Mr. Ward was disabled or that he intended to make a claim under the Policy. UNUM first became aware of Mr. Ward's potential claim on April 11, 1994. Mr. Ward did not submit a claim to UNUM for long term



disability benefits at the time of his alleged disability, which he claimed occurred on May 8, 1992, or at any time prior to April 11, 1994. Accordingly, by letter dated April 13, 1994, UNUM advised Mr. Ward that it was unable to review his application for benefits on the ground that proof of claim had not been submitted within the time frame specified under the Policy. A true and correct copy of UNUM's letter of April 13, 1994 is attached hereto as Exhibit 26.

9. Mr. Ward, through his attorney Brooks L. Iler, requested review of UNUM's claim denial by letter dated June 6, 1994. A true and correct copy of Mr. Iler's letter of June 6, 1994 is attached hereto as Exhibit 27.

10. By letter dated July 12, 1994, UNUM advised Mr. Ward and Mr. Iler that it had completed its review and that its initial determination had been upheld. The ground for UNUM's denial of benefits was that Mr. Ward had not submitted proof of claim within the time limit specified in the Policy in which he was a participant. A true and correct copy of UNUM's July 12, 1994 letter is attached hereto as Exhibit 28.

11. Had plaintiff timely filed his claim for disability benefits under the Policy, UNUM would have conducted a thorough claim investigation. In handling claims for long term disability benefits, it is UNUM's usual and customary practice to request from each of its insured's treating physicians copies of all office/treatment notes, basic laboratory data, test results and consultations for the patient's treatment period to evaluate a claim and to better understand a claimant's medical condition. Additionally, treating physicians are requested to provide UNUM with the patient's current restrictions and limitations, a detailed physical capacity evaluation, prognosis for return to work and the current course of treatment. Depending upon the information received, UNUM may schedule an independent medical examination of the claimant in order to obtain a second opinion regarding

the nature of the claimant's medical condition and disability and may conduct a vocational analysis.

12. Plaintiff submitted his claim to UNUM nearly two years after the onset of his disability. During that nearly two year period, UNUM was without knowledge that plaintiff claimed he was "disabled" and was thereby deprived of the opportunity to fully evaluate his claim and to determine the extent of his disability at the time he claimed to be disabled.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Executed on March 29, 1995, at Portland, Maine.

/s/ John A. Houser, III
JOHN A. HOUSER, III



## EXHIBIT 1

[Logo] Unionmutual

Policyholder:

MANAGEMENT ANALYSIS COMPANY

Policy Number: 310727

Policy Effective Date: November 1, 1983 *
* Revised by Amendment No. 05

Premium Due Dates:
January 1 and the first day of each following month.

Governing Jurisdiction: CALIFORNIA

Policy Anniversary:
November 1, 1986, and each following November 1

Unionmutual Stock Life Insurance Co. of America (referred to as the Company) will pay the benefits provided in this policy. The Company makes this promise subject to all of this policy's provisions.

The policyholder should read the policy specifications carefully and contact the Company promptly with any questions.

This policy is delivered in and governed by the laws of the governing jurisdiction.

Signed for the Company at Portland, Maine on the policy effective date.

/s/ [Illegible]
Secretary

/s/ [Illegible]
President

Unionmutual Stock Life Insurance Co. of America
A Stock Life Insurance Company

## SECTION VI—GENERAL POLICY PROVISIONS

* * * *

a. information relative to employees:

i. who qualify to become insured;

ii. whose amounts of insurance change; and/or

iii. whose insurance terminates.

b. any other information about this policy that may be reasonably required.

The employer's records which, in the opinion of the Company, have a bearing on the insurance will be opened for inspection by the Company at any reasonable time.

2. Clerical error or omission will not:

a. deprive an employee of insurance;

b. affect an employee's amount of insurance; or

c. effect or continue an employee's insurance which otherwise would not be in force.

### E. MISSTATEMENT OF FACTS

If relevant facts about any employee were not accurate:

1. a fair adjustment of premium will be made; and

2. the true facts will decide if and in what amount insurance is valid under this policy.

### F. NOTICE AND PROOF OF CLAIM

1. Notice

a. Written notice of claim must be given to the Company within 30 days of the date disability starts, if that is possible. If that is not possible, the Company must be notified as soon as it is reasonably possible to do so.



b. When the Company has the written notice of claim, the Company will send the insured its claim forms. If the forms are not received within 15 days after written notice of claim is sent, the insured can send the Company written proof of claim without waiting for the form.

2. Proof

a. Proof of claim must be given to the Company. This must be done no later than 90 days after the end of the elimination period.

b. If it is not possible to give proof within these time limits, it must be given as soon as reasonably possible. But proof of claim may not be given later than one year after the time proof is otherwise required.

c. Proof of continued disability and regular attendance of a physician must be given to the Company within 30 days of the request for the proof.

d. The prof must cover:

i. the date disability started;

ii. the cause of disability; and

iii. how serious the disability is.

### G. EXAMINATION

The Company, at its own expense, will have the right and opportunity to have an employee, whose injury or sickness is the basis of a claim, examined by a physician or vocational expert of its choice. This right may be used as often as reasonably required.

## H. LEGAL PROCEEDINGS

A claimant or the claimant's authorized representative cannot start any legal action:

1. until 60 days after proof of claim has been given; nor
2. more than 3 years after the time proof of claim is required.

## I. TIME OF PAYMENT OF CLAIMS

When the Company receives proof of claim, benefits payable under this policy will be paid monthly during any period for which the Company is liable.

## J. PAYMENT OF CLAIMS

All benefits are payable to the employee. But if a benefit is payable to an employee's estate, an employee who is a minor, or an employee who is not competent, the Company has the right to pay up to $1,000 to any of the employee's relatives whom the Company considers entitled. If the Company pays benefits in good faith to a relative, the Company will not have to pay such benefits again.

## K. WORKERS' OR WORKMEN'S COMPENSATION

This policy is not in lieu of, and does not affect, any requirement for coverage by workers' or workmen's compensation insurance.

## L. AGENCY

For all purposes of this policy, the policyholder acts on its own behalf or as agent of the employee. Under no circumstances will the policyholder be deemed the agent of the Company without a written authorization.



## SECTION I— POLICY SPECIFICATIONS

1. Description of Eligible Classes

   Class 1 President, Vice Chairman, Senior Vice President, Division Manager and Vice President

   Class 2 All other employees

2. Amounts of Insurance

   a. The lesser of:

      i. 60% of basic monthly earnings less other income benefits, except family Social Security benefits; or

      ii. 70% of basic monthly earnings, less all other income benefits; or

      iii. the maximum monthly benefit.

      Note: This benefit is subject to reductions for earnings as provided in the Monthly Benefit section of this policy.

   b. The maximum monthly benefit is $13,000.

   c. The minimum monthly benefit is the greater of:

      i. $100.; or

      ii. 10% of the monthly benefit before deductions for other income benefits.

3. Maximum Benefit Period

| Age at Disability | Maximum Benefit Period |
|---|---|
| Less than age 60 | To age 65 but not less than 60 months |
| 60 | 60 months |
| 61 | 48 months |
| 62 | 42 months |
| 63 | 36 months |
| 64 | 30 months |
| 65 | 24 months |
| 66 | 21 months |
| 67 | 18 months |
| 68 | 15 months |
| 69 and Over | 12 months |

4. Elimination Period: 90 days

5. Minimum Requirement for Active Employment:

   For Daily Salaried Consultants, 114 hours per month based on an average of paid hours from the previous 12 months.

   For Daily Salaried Consultants who have been paid a minimum of 2 months but less than 12 months, average will be based on hours paid for months paid.

   For all others: 30 hours per week

6. Definition of Basic Monthly Earnings

   For Daily Salaried Consultants

   "Basic monthly earnings" means 1/12th of salary only from November 1st through October 31st of the year prior to the date salary changes are made. Salary changes will be made January 1st of each year.

   For Daily Salaried Consultants with less than one year of service:

   "Basic monthly earnings" means 1/12th of 171 work days times the employees individual contractual daily work rate.

   For all other employees

   "Basic monthly earnings" means the insured's monthly rate of earnings from the employer in effect just prior to the 12 month period ending on November 1 of each year, actual changes will take effect January 1. It includes earnings from commissions, bonuses and overtime pay, but not other extra compensation.

   Commissions, bonuses and overtime pay will be averaged for the lesser of:

   a. the 12 month period of employment just prior to November 1; or



   b. the period of employment.

7. Waiting Period:

   a. Employees in an eligible class on or before the policy effective date: None

   b. Employees entering an eligible class after the policy effective date: First of the month following date of employment

   The employee must be in continuous active employment in an eligible class during the specified waiting period.

8. Employee Contributions Required: Yes

   Note: Coverage for which contributions are required applies only if proper enrollment is made and the required contributions are made.

9. Divisions, Subsidiaries or Affiliated Companies included

| Name | Location (City and State) |
|---|---|
| Pacific Atlantic Technical Services, Inc. | Atlanta, GA |
| MACTEC | San Diego, CA |

10. Changes Effective

    Subject to the Delayed Effective Date subsections, changes in insurance take effect each November 1.

11. Continuation of Employee Insurance During Absences

| Type of Absence | Time Limit |
|---|---|
| Temporary Layoff or Leave of Absence | To the end of the 3 month period following the policy month in which the layoff or leave of absence begins. |

## SECTION II—DEFINITIONS

For the purposes of this policy:

"Active employment" means the employee must be working:

1. for the employer on a permanent full-time basis and paid regular earnings;
2. at least the minimum number of hours shown in the policy specifications; and either
3. at the employer's usual place of business; or
4. at a location to which the employer's business requires the employee to travel.

"Basic monthly earnings"—As defined in the policy specifications.

"Certificate" means a written statement prepared by the Company including all riders and supplements, if any, setting forth a summary of:

1. the insurance benefits to which an employee is entitled;
2. to whom the benefits are payable; and
3. limitations or requirements that may apply.

"Complications of pregnancy" means pregnancy complicated by concurrent disease or abnormal conditions significantly affecting usual medical management.

"Disability" or "disabled"—see last page of Section II.

"Disability benefits," when used with the term retirement plan, means money which:

1. is payable under a retirement plan due to disability as defined in that plan; and



2. does not reduce the amount of money which would have been paid as retirement benefits at the normal retirement age under the plan if the disability had not occurred. (If the payment does cause such a reduction, it will be deemed a retirement benefit as defined in this policy.)

"Eligibility date" means the date an employee becomes eligible for insurance under this policy. Classes eligible are shown in the policy specifications.

"Elimination period" means a period of consecutive days of disability for which no benefit is payable. The elimination period is shown in the policy specifications and begins on the first day of disability.

Note: If disability stops during the elimination period for any 7 (or less) days, then the disability will be treated as continuous. But days that the insured is not disabled will not count toward the elimination period.

"Employee" means a person in active employment with the employer.

"Employer" means the policyholder and includes any division, any subsidiary or any affiliated company named in the policy specifications.

"Evidence of insurability" means a statement or proof of an employee's medical history upon which acceptance for insurance will be determined by the Company.

"Grace period" is the 31 days folowing a premium due date during which premium payment may be made.

"Gross monthly benefit" means the insured's benefit amount before any reduction for other income benefits and earnings.

"Home office" means the Unionmutual Stock Life Insurance Co. of America, 2211 Congress Street, Portland, Maine 04122.

"Indexed pre-disability earnings" means the insured's basic monthly earnings in effect just prior to the date his disability began adjusted by 7% on the first anniversary of benefit payments and each following anniversary to a maximum of 5 adjustments.

"Injury" means bodily injury resulting directly from an accident and independently of all other causes. The injury must occur and disability must begin while the employee is insured under this policy.

"Insured" means an employee insured under this policy.

"Male pronoun" whenever used includes the female.

"Monthly Benefit" means the amount payable by the Company to the disabled insured.

"Partial disability" or "partially disabled"—see last page of Section II.

"Physician" means a person who is:

1. operating within the scope of his license; and either
2. licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. legally qualified as a medical practitioner and required to be recognized, under this policy for insurance purposes, according to the insurance statutes or the insurance regulations of the governing jurisdiction.

It will not include an employee or his spouse, daughter, son, father, mother, sister or brother.



"Policy Specifications" is the document showing the eligible classes, the amounts of insurance and other relevant information pertaining to the plan of insurance applied for by the policyholder. This document, designated Section I, is attached to and is part of this policy.

* * * *

MAC

MANAGEMENT ANALYSIS COMPANY

Your Long Term Disability Income Benefits



TABLE OF CONTENTS


| | Page |
|---|---|
| CERTIFICATE OF COVERAGE | 1 |
| PLAN OUTLINE | 2 |
| TERMS YOU SHOULD KNOW | 6 |
| ENROLLMENT AND DATE INSURANCE STARTS | 11 |
| DISABILITY | 12 |
| RECURRENT DISABILITY | 15 |
| SURVIVOR BENEFIT | |
| GENERAL EXCLUSIONS | 16 |
| PRE-EXISTING CONDITION EXCLUSION | 17 |
| PRE-EXISTING CONDITION EXCLUSION | 17 |
| MENTAL ILLNESS LIMITATION | 17 |
| CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIERS | 18 |
| TERMINATION | 20 |
| CONVERSION PRIVILEGE | 21 |
| SOME GENERAL INFORMATION TO KNOW | 22 |

## CERTIFICATE OF COVERAGE

This certificate does not apply unless this space is covered by sticker form 100-77

UNUM Life Insurance Company of America (referred to as "we," "our" and "us") welcomes your employer as a client.

This is your certificate of coverage as long as you are eligible for insurance and you become and remain insured. Keep it in a safe place.

A few words about this certificate of coverage. . . .

We have written it in plain English. But a few terms and provisions are written as required by insurance law. You will want to read it carefully. If you have any questions about any terms and provisions, please contact the Insurance Administrator at your work location or write to our claims paying office. We will assist you in any way we can to help you understand your benefits.

Also, if the terms of your certificate of coverage and the policy differ, the policy will govern. Your coverage may be terminated or modified in whole or in part under the terms and provisions of the policy.

/s/ Jerry F. Orr, III

President



## PLAN OUTLINE

Description of Eligible Classes

President, Vice Chairman, Senior Vice President, Division Manager and Vice President

Amount of Insurance

- The lesser of:
  1. 60% of basic monthly earnings less other income benefits, except family Social Security benefits; or
  2. 70% of basic monthly earnings, less all other income benefits; or
  3. the maximum monthly benefit.

     Note: This benefit is subject to reductions and earnings as provided in the section titled "How is the benefit figured?"
- The maximum monthly benefit is $13,000.
- The minimum monthly benefit is the greater of:
  1. $100.00; or
  2. 10% of the monthly benefit before deductions for other income benefits.

## CONVERSION PRIVILEGE

Under what conditions can you convert?

When your insurance under this plan terminates because you end employment with the policyholder, you may obtain converted disability income coverage without medical evidence of insurability. But you must have been insured for at least twelve consecutive months just before your insurance under this plan terminated. These twelve months will be considered to include the time you were

insured for group long term disability under both this plan and the one it replaced, if any.

Who may not convert?

The conversion privilege is not available to you if:

1. your insurance under this plan terminates for any of the following reasons:
   a. this plan terminates;
   b. this plan is amended to exclude from coverage the class of employees to which you belong;
   c. you no longer belong to a class of employees eligible for coverage under this plan;
   d. you retire;
   e. you failed to pay any required premium;
2. you are or become insured for long term disability insurance under another group plan within 31 days after termination; or
3. you are disabled under the terms of this plan.

When must you apply for the conversion coverage?

You must apply for and pay the first quarterly premium for the conversion coverage within 31 days after your insurance terminates under this plan.

Is the conversion coverage the same as that provided under this plan?

The Company governs the form of coverage, the benefits and the amounts. The benefit and amounts may differ from those under this plan.

## SOME GENERAL INFORMATION TO KNOW

When must we be notified of a claim?



You must give us written notice of claim within 30 days of the date disability starts. If that is not possible, you must notify us as soon as you can.

When we receive your written notice of claim, we will send you our claim forms. If you do not receive the forms within 15 days after you sent the notice, you can send written proof of claim without waiting for the form.

When does proof of claim have to be given?

You must give us proof of claim no later than 90 days after the end of the elimination period.

If it is not possible for you to give proof within these time limits, it must be given as soon as reasonably possible. But you may not give proof later than one year after the time it is otherwise required.

You must give us proof of continued disability and regular attendance of a physician within 30 days of the date we request the proof.

The proof must cover:

1. the date disability started;
2. the cause of disability; and
3. how serious the disability is.

When are claims paid?

When we receive proof of claim, benefits payable under the policy will be paid monthly during any period for which we are liable.

Who are claims paid to?

All benefits are payable to you. But if a benefit is payable to your estate, or if you are a minor, or you are not competent, we have the right to pay up to $1,000 to any of your relatives whom we consider entitled. If we pay bene-

fits in good faith to a relative, we will not have to pay such benefits again.

What are our examination rights?

We, at our expense, have the right and opportunity to have you examined by a physician or vocational expert of our choice to determine the extent of any sickness or injury for which you have made a claim. This right may be used as often as reasonably required.

How can statements made in any application for this insurance be used?

In the absence of fraud, all statements you made when applying for this insurance and providing evidence of insurability are considered representations and not warranties (absolute guarantees). No statements by you will be used to reduce or deny a claim:

1. after 2 years from your most recent effective date of insurance; and

2. unless a copy of your statements has been given to you.

Can legal proceedings be stated at any time?

No, you or your authorized representative cannot start any legal action:

1. until 60 days after proof of claim has been given; nor

2. more than 3 years after the time proof of claim is required.

What happens if facts are misstated?

If relevant facts about you were not accurate:

1. a fair adjustment of premium will be made; and



2. the true facts will decide if and in what amount insurance is valid.

Does this coverage affect workers' or workmen's compensation?

The policy is not in lieu of, and does not affect, any requirement for coverage by workers' or workmen's compensation insurance.

## SUMMARY PLAN DESCRIPTION

Name of Plan:

MANAGEMENT ANALYSIS COMPANY

Policy No.: 310727

Participants Included: See Plan Outline
Name and Address of Employer
MANAGEMENT ANALYSIS COMPANY
12671 High Bluff Drive
San Diego, California 92130

Who Pays For the Plan: The cost of the plan is shared by both you and your employer.

Plan Identification Number

a. Employer IRS Identification No.: 95-3139094

b. Plan No.: 000503

Plan Year: January 1

Plan Administrator, Name, Address and Telephone No.
MANAGEMENT ANALYSIS COMPANY
12671 High Bluff Drive
San Diego, California 92130
(619) 452-5000

Agent for Service of Legal Process on the Plan
Same as above

Loss of Benefits

On any premium due date the policyholder may terminate the policy(ies) or, subject to the insurance company's approval, may modify, amend or change the provisions, terms and conditions of the policy(ies). No consent of any participant or any other person referred to in the policy(ies) shall be required to terminate, modify, amend, or change the policy(ies).

NOTE: If you cease active employment, see your supervisor to determine what arrangements, if any, may be made to continue your coverage beyond the date you cease active employment.

What are your rights in the event of plan termination?

Termination of this policy under any conditions will not prejudice any payable claim which occurs while this plan is in force.

When may the plan terminate?

1. If the policyholder fails to pay any premium within the grace period, this policy will automatically terminate at 12:00 midnight of the last day of the grace period. The "grace period" is the 31 days following a premium due date during which premium payment may be paid.

2. The policyholder may terminate this policy by advanced written notice delivered to the insurance company at least 31 days prior to the termination date. But this policy will not terminate during any period for which premium has been paid.

3. The insurance company may terminate this policy on any premium due date by giving written notice to the policyholder at least 31 days in advance if:
   a. The number of employees insured is less than 10; or



   b. Less than 100% of the employees eligible for any noncontributory insurance are insured for it; or
   c. Less than 75% of the employees eligible for any contributory insurance are insured for it; or
   d. The policyholder fails:
      i. To furnish promptly any information which the insurance company may reasonably require; or
      ii. To perform any other obligations pertaining to this policy.

4. Termination may take effect on any earlier date when both the policyholder and the insurance company agree.

What are your rights under ERISA?

1. As a participant in this plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:
   a. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents including insurance contracts, and copies of all documents filed by the Plan with the U. S. Department of Labor, such as detailed annual reports and plan descriptions.
   b. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
   c. Receieve a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

3. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

4. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

5. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

6. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

7. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The



court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

8. If you have any questions about your Plan, you should contact the Plan Administrator.

9. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U. S. Labor-Management Services Administration, Department of Labor.

What if your claim is denied?

In the event that your claim is denied, either in full or in part, the insurance company will notify you in writing within 90 days after your claim form was filed. Under special circumstances, the insurance company is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from the insurance company indicating the reason for the delay and the date you may expect a final decision. The insurance company's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those policy provisions on which the denial is based;

2. A description of any additional material or information necessary to complete the claim and an explanation of why that material or information is necessary; and

3. The steps to be taken if you or your beneficiary wish to have the decision reviewed.

Please note that if the insurance company does not respond to your claim within the time limits set forth above, you should automatically assume that your claim has been denied and you should begin the appeal process at that time.

What do you do to appeal?

You, the claimant, or your authorized representative may appeal a denied claim within 60 days after you receive the insurance company's notice of denial. You have the right to:

1. Submit a request for review, in writing, to the insurance company;

2. Review pertinent documents; and

3. Submit issues and comments in writing to the insurance company.

The insurance company will make a full and fair review of the claim and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension, and a decision shall be made not later than 120 days following receipt of the request for review. The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those policy provisions upon which the final decision is based.



Plan Arranged by
FINANCIAL ADVISORY SERVICES
12555 High Bluff Dr.
Suite 333
San Diego, CA 92130

[Logo] UNUM

Underwritten by
UNUM Life Insurance Company of America
Portland, Maine

MAC

Management Analysis Company
12671 High Bluff Drive, San Diego, CA 92130
Mail: P.O. Box 85404, San Diego, CA 92186-5404
619-481-3100
FAX: 619/259-5070

April 6, 1994

UNUM
Western Regional Benefits
101 North Brand Blvd.
Suite 800
Glendale, CA 91203

Dear Sir:

Attached is a Long Term Disability claim for John E. Ward. As part of his claim, I am sending you a copy of his 1991 and 1992 W-2, a copy of his LTD enrollment (Mutual Benefit Life Insurance Company was the carrier at the time), and a copy of his most recent resume since no job description is available.

Please contact me at 619-259-5035 if there is any other information you need.

Sincerely,

/s/ Maria Bonney
MARIA BONNEY
Human Resources Supervisor

Attachments



UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA
Case No. 94-1454H (AJB)

---

JOHN E. WARD,
*Plaintiff,*

vs.

MANAGEMENT ANALYSIS COMPANY
EMPLOYEE DISABILITY BENEFIT PLAN,
*Defendant.*

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Date: July 24, 1995

Courtroom of the Honorable Marilyn L. Huff

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DECLARATION OF DEXANA MACQUARRIE

I, Dexana MacQuarrie, declare as follows:

1. I am Vice-President of Human Resources of Management Analysis Company ("MAC") and have been employed with MAC since October 1978. I have held my current position for the last four years. The facts stated in this declaration are personally known to me and, if called as a witness, I could and would testify competently about these facts.

2. As Vice-President of Human Resources, my duties currently include, and have always included, overseeing the operations of MAC's Human Resources department.

3. During the time that John E. Ward was President and CEO of MAC, I met with Mr. Ward annually to review all of BAC's insurance plans, including its long-term disability plan underwritten by UNUM (the "MAC

Plan"). Based upon these meetings, Mr. Ward and I would choose MAC's various insurance plans each year and submit them to MAC's Board of Directors for approval.

4. MAC's Human Resources department relied upon each of the insurance carriers and their respective policy documents to inform us about the procedures for submitting claims. In overseeing the operations of MAC's Human Resources department, I ensured that MAC followed the procedures set forth in the respective plan booklets, including the MAC Plan.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on June 26, 1995, at Golden, Colorado.

/s/ Dexana MacQuarrie
DEXANA MACQUARRIE



UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

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Case No. 94-1454H (AJB)

JOHN E. WARD,
*Plaintiff,*
vs.
MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN,
*Defendant.*

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Date: July 24, 1995

Courtroom of the Honorable Marilyn L. Huff

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## DECLARATION OF MARIA E. BONNEY

I, Maria E. Bonney, declare as follows:

1. I was an employee of Management Analysis Company ("MAC") for approximately ten years, from 1984 through 1994. I was the supervisor of Human Resources at MAC for approximately four years, from 1990 to November 17, 1994. Prior to that position, I was an employment administrator at MAC for approximately two years and prior to that position, I was a project assistant for four years. The facts stated in this declaration are personally known to me and, if called as a witness, I could and would testify competently about these facts.

2. During my four years as supervisor of Human Resources at MAC, the Human Resources department was

responsible for enrolling MAC employees in MAC's insured benefit plans, such as health insurance, life insurance and long-term disability insurance. Human Resources sent enrollment form to its employees who were eligible for these benefits. After the enrollment process was completed, a report would be generated and sent to UNUM listing the enrolled MAC employees for, among other things, long-term disability ("LTD") coverage. A check or checks would also be sent to the insurer each month, representing payment of premiums for the enrolled employees. Employees who enrolled for LTD coverage paid the entire amount of their premiums. The premiums would be deducted from and reflected on the employees' paychecks. Human Resources also monitored the amount of paid leave, sick leave and vacation time MAC employees took and had some responsibility for MAC's ESOP, 401(k) plan and Section 125 plan.

3. During each of my four years as supervisor of Human Resources at MAC from 1990 through 1994, MAC's long-term disability ("LTD") plan was underwritten by UNUM Life Insurance Company of America ("UNUM") and was called the Management Analysis Company Plan (the "MAC Plan"). We relied upon UNUM and the MAC Plan's documents to advise us regarding LTD claims procedures under the MAC Plan.

4. As a matter of course, MAC Plan certificates were issued to all participating MAC employees, including the then President and CEO of MAC, Mr. John E. Ward.

5. While I was the supervisor of Human Resources at MAC, I assisted MAC employees in submitting LTD claims to UNUM on five occasions. One of those claims was the claim submitted by Mr. Ward in April of 1994.

6. There are three parts to a UNUM LTD claim. The employee completes the Application for Disability Benefits and the Authorization. The attending physician completes the Attending Physician's Statement. The employer completes the Employer's Statement of Claim.



7. It was always my understanding that claims were not submitted until they were submitted to UNUM. In each of the five instances when I assisted MAC employees in submitting to UNUM, I advised those employees, including Mr. Ward, that their claims were not submitted until they were submitted to UNUM.

8. I assisted four MAC employees, in addition to Mr. Ward, with their LTD claims under the MAC Plan. In two instances, I simply sent the claims forms to the employees, and they, in turn, submitted their applications directly to UNUM. In another instance, the employee received his application directly from UNUM and submitted it directly to UNUM; I had very little involvement in assisting him. I separately sent the Employer's Report to UNUM in each of these three instances. In another instance, I provided the employee's wife with an application. The completed application was sent back to me by the employee's wife and I forwarded the application and the Employer's Report to UNUM.

9. When Mr. Ward first requested an LTD application from me in late March 1994, I advised him that his claim would be untimely under the time frame set forth in the MAC Plan. Mr. Ward acknowledged his understanding that the deadline for submitting claims under the terms of the MAC Plan had passed, but stated that he wanted to file a claim anyway.

10. I understood from my reading of the MAC Plan's documents that, without a written authorization, MAC was not the agent of UNUM. Rather, MAC acted on its own behalf or on behalf of MAC employees in submitting claims to UNUM. At no time during my employment as supervisor of Human Resources at MAC, did MAC ever receive written authority to act as the agent of UNUM.

11. I have reviewed Mr. Ward's declaration of April 24, 1995. Paragraph 4 of that declaration is incorrect. I never had a telephone conversation with Mr. Ward in August or September of 1992. The first time I spoke with Mr. Ward regarding his available LTD benefits was in early 1994. At that time, Mr. Ward called me and asked whether he had benefits. After I checked his employment file, I told Mr. Ward that he was enrolled in the MAC Plan at the time of his employment with MAC. I did not have any conversation with Mr. Ward regarding the MAC Plan or Mr. Ward's disability until early 1994.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on June 26, 1995, at San Diego, California.

/s/ Maria E. Bonney
MARIA E. BONNEY



IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF CALIFORNIA

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Case No. 94-1454H (AJB)

JOHN E. WARD,
*Plaintiff,*

v.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN,
*Defendant,*

---

DEPOSITION OF JOHN E. WARD

San Diego, California

May 31, 1995

* * * *

Q. Well, didn't you reviewe all of the plans on an annual basis with the vice president in charge of administration?

A. Yes.

Q. And during this time period you were president, were you aware that MAC had a long-term disability plan available for its employees?

A. I think the answer is generally yes. I relied heavily upon the human resource manager to manage the details of all of our programs. And, as I mentioned, I became deeply involved in the health care program because of the costs. We were essentially self-insured.

Q. In 1989 what health care plan did you have in place at that time?

A. I don't remember. I don't remember who was the carrier at that time.

Q. Do you recall the carrier in 1992, at the time that you terminated employment?

A. I do not remember who its was. We frequently changed because of the economic aspects.

O. During the time that you were president, did you have the final say as to what benefit plans would be offered to MAC employees?

A. The approval process was normally that the vice president of support services—that was the right title—would make a recommendation to me. I would, if I approved, which I normally did, would present it to the board of directors, and they'd be accepted by the board.

* * * *



UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

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Case No. 95-1454H (AJB)

JOHN E. WARD,
*Plaintiff,*

v.

MANAGEMENT ANALYSIS COMFANY EMPLOYEE DISABILITY BENEFIT PLAN
*Defendant.*

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DEPOSITION OF DEXANA MACQUARRIE

San Diego, California

March 7, 1995

* * * *

Q. Had you ever read that booklet?

A. No.

Q. Did you attend a meeting in late 1991 or early 1992 regarding disability benefits?

A. I attended the employee meeting that we had on the overall benefits program, yes.

Q. That was a poorly worded question. You attended that meeting. Do you recall whether or not there was a presentation regarding disability benefits at that meeting.

A. Yes, there was.

Q. And who gave that presentation, if you know?

A. The UNUM representative.

O. Do you remember who that was?

A. I'm sorry. I don't. It's a sales rep.

Q. Do you remember what the presentation consisted of?

A. It was a summary of the benefit, and I think it was very brief and just summarized what the benefits to the plan were and that it was totally voluntary on the employees' part, paid for by the employees and the value of it.

Q. Do you know if Mr. Ward attended that meeting?

A. Yes, he did.

Q. Do you know if he was there during the presentation of the disability portion of the meeting by the UNUM rep?

A. Yes, he was.

Q. Prior to this were the employees advised who was eligible and who wasn't eligible, or was just everybody invited?

A. To the meeting?

Q. Yes.

A. Everyone was invited.

Q. As of mid-1992, do you have an estimate of how many people were participating in the disability portion of the plan?

A. No.

Q. Do you have an estimate of how many people were eligible to participate?

A. As of mid-'92?

Q. Right.

A. 400.

Q. That's your best estimate?

A. Yes.

Q. Is there any writing that describes your job description at it existed in mid-1992?

A. No.

Q. When did you first become aware that Mr. Ward was going to leave the company?

A. May 1992.

Q. How did you become aware of that?

A. I don't recall who told me.

• • • •



[Filed Sep. 19, 1994]

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF CALIFORNIA

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Case No. 941454H (AJB)

JOHN E. WARD,

*Plaintiff*,

v.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN,

*Defendant*.

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# COMPLAINT TO RECOVER BENEFITS AND FOR DECLARATION OF BENEFITS; REQUEST FOR JURY

(29 U.S.C. 1132)

Plaintiff JOHN E. WARD alleges as follows:

1. Jurisdiction of this Court arises out of and is based upon Section 502 of the Employee Retirement Income Security Act of 1974 ("ERISA") and also arises under 18 U.S.C. 1132.

2. The plaintiff, JOHN E. WARD, is a qualified and vested participant of the MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN ("the Plan") which is an employee disability insurance benefit plan established pursuant to and in accordance with the provisions of ERISA as set forth in 18 U.S.C. 1001, et seq.

3. The Plan is administered by Management Analysis Company. ("MAC"). Both the Plan and MAC have an office and regular place of business in San Diego, California.

4. Plaintiff was an employee of MAC continuously from March 21, 1983 until he became permanently disabled on or about May 5, 1992.

5. The Plan consists of disability insurance coverage underwritten by UNUM Life Insurance Company of America. ("UNUM").

6. MAC adopted the Plan effective November 1, 1983.

7. Plaintiff has duly complied with all conditions necessary to receive disability benefits as described in the Plan.

8. On or about May 5, 1992 plaintiff learned that he was permanently disabled. This was a factor in his decision to retire on May 10, 1992.

9. On or before March 30, 1993 plaintiff advised Dexana G. MacQuarrie, MAC's employee benefits administrator ("Administrator") that he was permanently disabled and would no longer be able to continue any regular employment. Plaintiff requested assistance from Administrator in obtaining benefits under various employee benefit plans administered by MAC, including but not limited to application for extended health insurance benefits due to his total disability and recovery of certain retirement benefits provided by MAC under an employee retirement benefit plan. Plaintiff relied on the Administrator to advise and aid him in protecting any and all rights and recovering any and all benefits available to plaintiff under any MAC employee benefit plans as a result of plaintiff's disability.

10. At all times herein relevant, the Administrator was acting as an agent of UNUM in performing the functions necessary to administer the disability insurance provided by the Plan. Therefore, notice of plaintiff's permanent disability constituted notice to UNUM for purposes of making a claim for disability benefits under the Plan.

11. On or about April 6, 1994, despite having previously provided notice of his permanent disability to



UNUM's agent, Administrator, plaintiff made a written claim for disability benefits directly to UNUM. (Ex. 1.)

12. On or about April 13, 1994 UNUM denied plaintiffs' claim for disability benefits under the Plan, stating that no timely claim therefore had been made. (Ex. 2.).

13. On or about June 6, 1994 plaintiff timely filed his appeal of UNUM's denial of benefits to UNUM Ltd. Quality Review Section pursuant to the administrative procedures set forth in UNUM's benefits denial letter and disability insurance policy. Plaintiff therein set forth citations to legal authority holding that the Administrator is the agent of the insurer for purposes of employee benefits plans regulated by ERISA. Plaintiff also renewed his demand for benefits under the Plan. (Ex. 3.).

14. On or about July 12, 1994 UNUM again denied benefits to plaintiff under the disability Plan. (Ex. 4.).

15. Plaintiff has now exhausted any and all available administrative remedies with respect to this claim for disability benefits under the Plan.

16. The denial of plaintiff's claim to rights and benefits under the Plan was arbitrary, unreasonable and not supported by law.

17. An actual controversy has now arisen between plaintiff and defendant regarding the parties' rights and liabilities under the Plan. Plaintiff desires a judicial determination of those rights and duties under the Plan.

18. As a direct and proximate result of the Plan's failure and refusal to provide disability benefits under the Plan, plaintiff has sustained damages in an amount not now certain. On information and belief, plaintiff alleges that he has sustained, and will continue to sustain damages equal to the amount of benefits due plaintiff in accordance with the disability insurance policy provided by the Plan in an amount not less than $13,000.00 per month for a period of 42 months commencing from the onset of

his disability. Plaintiff alleges that he will continue to sustain similar damage until such time as plaintiff is no longer disabled or until the full benefits under the policy are paid.

19. As a further direct and proximate result of defendant's failure and refusal to provide benefits under the Plan, plaintiff has incurred and will continue to incur attorneys' fees in an amount not yet certain.

WHEREFORE, plaintiff requests judgment against the Plan as follows:

1. Declaring that plaintiff's claim for benefits under the Plan is not barred for untimeliness;

2. Awarding plaintiff a money judgment for all accrued disability benefits under the Plan which are due and owing at the time of judgment;

3. Declaring that plaintiff will continue to be entitled to collect disability benefits under the Plan until such time as he is no longer disabled or until full benefits have been paid pursuant to the Plan.

4. Awarding plaintiff prejudgment interest from May 5, 1992 until the date of judgment.

5. Awarding plaintiff attorneys' fees, court costs and other reasonable costs incurred.

6. For such other and further relief as the court may deem just and proper.

DATED: 9/15/94

SHAFFMAN, ILER, PALKOWITZ & DOFT

By: /s/ Brooks L. Iler
BROOKS L. ILER
Attorney for plaintiff



## DEMAND FOR JURY TRIAL

Pursuant to Federal Rules of Civil Procedure, rule 38, plaintiff hereby demands a trial by jury in this action.

DATED: 9/15/94

SHAFFMAN, ILER, PALKOWITZ & DOFT

By: /s/ Brooks L. Iler
BROOKS L. ILER
Attorney for plaintiff

UNUM.

**Long Term Disability Claim**
**Employer's Statemen**

**To Be Completed By The Employer**

| This claim is for (Employee's Name) | Social Security Number | Date of Birth |
|---|---|---|
| John E. Ward - | 565-32-1294 | 4/24/30 |

**A. Information about the employer**

| Company's Name | Group Policy Number |
|---|---|
| Management Analysis Company | 0310727-001-3 |
| Address (Street, City, State, Zip) | Telephone: (619) 259-5035 |
| 12671 High Bluff Drive , San Diego, CA 92130 | Fax: (619) 259-5046 |

Name and address of division where employee works (if different from above)

**B. Information about the employee**

| Date employee was hired (Month, Day, Year) | Date employee became insured under this plan? | What was the employee's regularly schedule work week? |
|---|---|---|
| 3/21/83 | 3/21/83 | 40 hours per week |

**C. Information needed for withholding and reporting taxes**

Does employee contribute post-tax dollars toward the premium? ☒ Yes ☐ No If yes, what percent is paid by the employee? 100 %
**If you leave this section blank, we will assume it is 100% employer contribution and calculate FICA taxes accordingly.**

**D. Information about the claim**

Were there any changes to the employee's job responsibilities due to the disabling condition before the employee became fully disabled?
☐ Yes ☒ No If yes, what were the changes and when were they made?

| What was the employee's permanent job on his or her last day at work? | How long had the employee been in this job? |
|---|---|
| President/CEO | 7/6/87 - 3/8/92 |

| Last day employee actually worked (Month, Day, Year) | On that day, did the employee work a full day? |
|---|---|
| ~~3/8/92~~ May 8, 1992 mdw | ☒ Yes ☐ No If no, how many hours were worked? |

| Why did employee stop working? | Is the employee's condition work related? |
|---|---|
| Board of Directors requested his resignation | ☐ Yes ☒ No |

Has a claim been filed with Worker's Compensation?
☐ Yes ☒ No If yes, send initial report of illness or injury and award notice.

Name and Address of your compensation carrier
n/a

Name and Address of your medical insurance carrier
n/a

**E. Information about your pension plan (do not complete for maternity claim)**

| Do you have a pension plan? | If yes, what type? | | | |
|---|---|---|---|---|
| ☒ Yes ☐ No | ☐ Defined benefit | ☒ 401(k) | ☒ Other: (specify) | ESOP |
| | ☐ Defined contribution | ☐ Profit sharing | | |

| Is the employee eligible for your pension plan? | If eligible, does the employee participate? |
|---|---|
| ☒ Yes ☐ No If no, why? | ☒ Yes ☐ No If no, why? |

If the employee is participating, when is he or she eligible for benefits under the plan? (Month, Day, Year)
401(k) - received entire account balance 7/92 ESOP - will receive 5 payments over 5 years

**F. Information about your rehire or return-to-work policies**

Does your company have a rehire or return-to-work policy for disabled employees?
☐ Yes ☒ No

What is the name and title of the manager we should contact if we identify a rehabilitation or return-to-work option?

**G. Information about the employee's salary**

The employee (Check all that apply)
☐ is paid hourly (what is the hourly rate?) $ _____ ☒ is salaried ☐ receives commissions ☐ receives bonuses

Is employee file for disability benefits provided by any employer/employee labor management, state disability or union welfare plan?
☒ Yes ☐ No If yes, what is the weekly amount? $ 336 When do benefits begin? 3/10/93 End? ?

Is this employee eligible for salary continuation?
☐ Yes ☒ No If yes, what is the weekly amount? $ _____ When do benefits begin? _____ End? _____

(Continued on Reverse)

BEST AVAILABLE COPY

eporting the employee's basic monthly earnings (For assistance, call the benefits office 800 number shown on the inside front cover of this form)

nd the definition of basic monthly earnings that matches your contract for this employee and follow the instructions given.

efinitions of Basic Monthly Earnings

salary only (no commissions, bonuses, etc.), complete question 1 below
previous year's W-2 form, complete question 5 below (attach W-2)
sole proprietor, complete question 8 below
previous year's K-1 form, complete question 6 below (attach K-1)

. salary and commissions, complete questions 1 and 3 below
salary, commissions and bonuses, complete questions 1, 3 and 4 below
salary and deferred compensation, complete questions 1 and 2 below
salary, deferred compensation and commissions, complete questions 1, 2, and 3 below
salary, deferred compensation, commissions and bonuses, complete questions 1, 2, 3, and 4 below
salary and K-1 earnings, complete questions 1 and 6 below

. W-2 with deferred compensation, complete questions 2 and 5 below
partnership agreement, complete question 7 below
. teacher's contract, complete question 1 below
. any other definition, complete question 9 below

84a

) On the last day the employee worked, what was his or her basic monthly salary?
(Divide annual salary by 12 or multiply weekly salary by 52 and divide by 12. Teachers divide annual salary by 12) 1 $19,583.33

) On the last day the employee worked, what was his or her monthly pre-tax contribution to your deferred compensation plan? 2 n/a

) How much had the employee received in commissions in the 12 months (or the period of employment if less than 12 months) immediately preceding the last day worked? $ _____.
Divide this number by 12, or the length of employment if less than 12 months, to find the average monthly commissions. 3 n/a

) How much had the employee received in bonuses in the 12 months (or the period of employment if less than 12 months) immediately preceding the last day worked? $ _____.
Divide this number by 12, or the length of employment if less than 12 months, to find the average monthly bonuses. 4 _____

) What were the employee's earnings as shown on the W-2 form of the year immediately preceding the disability? 1991 5 $232,553

) What were the employee's earnings as shown on the K-1 form of the year immediately preceding the disability? 6 n/a

) As of the last day the employee worked, what were the budgeted annual earnings as determined by the written partnership agreement in effect? (Do not include dividends, interest or return of capital) $ _____. 7 n/a

) As of the last day the employee worked, what was the sole proprietor's annual net profit (1040 Schedule C gross income minus total deductions minus depreciation) averaged over the 3 years immediately preceding the disability or the period of sole proprietorship if less than 3 years? 8 n/a

) For definitions other than those above, calculate the monthly earnings as they are defined in your contract. If earnings are based on salary as expressed on a particular document, send us a copy of the document. 9 n/a

**. Required Attachments and Signature**

the employee contributes to the premiums, attach a copy of the enrollment form.
salary is based on a W-2, K1, 1099, or a similar document, attach a copy of the document.
you have medical information from the employee's file relating to this disability, please attach copies.
a worker's compensation claim is filed, send initial report of injury or illness and award notice.

ame of person completing this form (If this claim is approved for disability benefits, the benefit check will be sent to the employee with a carbon copy to you.)

Maria Bonney

7

Maria Bonney — Signature
Human Resources Supervisor — Title
4/6/94 — Date

) UNUM.

**Long Term Disability Claim**
**Job Analysis**

e Completed By The Employee's Supervisor

(Claim is for (Employee's Name)

John E. Ward

Employee's Social Security Number: 565-32-1294

Date of Disability (Month, Day, Year): Social Security determination 5/10/92

General information about the employee's job

Title: President/CEO

Minimum education or training required: B.S. or B.A.

Does the employee perform supervisory functions?
☒ Yes ☐ No If yes, how many people are supervised? entire staff - 500 Describe job duties.

CEO for management consulting firm

Check the items below that relate to the employee's job. Use these definitions for the frequency of occurrence:
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

| | Occasionally | Frequently | Continuously |
|---|---|---|---|
| ate to others | ☐ | ☐ | ☒ |
| tten and verbal communication | ☐ | ☒ | ☐ |
| asoning, math and language | ☐ | ☐ | ☒ |
| akes independent judgments | ☐ | ☐ | ☒ |

Which of the following describe the employee's working environment? Check all that apply.
☐ Unprotected heights ☐ Changes in temperature or humidity ☐ Exposure to dust, fumes and gases
☐ Being near moving machinery ☒ Driving automotive equipment ☐ Other hazards

Is the employee required to travel?
☒ Yes ☐ No If yes, complete the following information:

| How does the employee travel? (Automobile, plane, train, etc.) | Where does the employee travel? | What percent of the time does the employee travel? |
|---|---|---|
| auto, plane, train | U.S. and occasionally overseas | 25% |

Information about the physical aspects of the employee's job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

| Activity | Occasionally | Frequently | Continuously |
|---|---|---|---|
| ☒ Standing | ☐ | ☒ | ☐ |
| ☒ Walking | ☐ | ☒ | ☐ |
| ☒ Sitting | ☐ | ☒ | ☐ |
| ☐ Balancing | ☐ | ☐ | ☐ |
| ☐ Stooping | ☐ | ☐ | ☐ |
| ☐ Kneeling | ☐ | ☐ | ☐ |
| ☐ Crouching | ☐ | ☐ | ☐ |
| ☐ Crawling | ☐ | ☐ | ☐ |
| ☒ Reaching/working overhead | ☒ | ☐ | ☐ |
| ☒ Climbing: | ☐ | ☐ | ☐ |
| ☒ Stairs | ☒ | ☐ | ☐ |
| Number of stairs: 1 flight (elevator available) | | | |
| ☐ Ladders | ☐ | ☐ | ☐ |
| Height of Ladder: _____ | | | |
| ☐ Pushing | ☐ | ☐ | ☐ |
| ☐ Pulling | ☐ | ☐ | ☐ |
| ☒ Lifting/carrying | ☒ | ☐ | ☐ |

| Describe Activity | Weight |
|---|---|
| _____ | _____ lbs. |
| _____ | _____ lbs. |
| Proposals, presentations briefcase | 15-20 lbs. |

8

858

...e job be performed by alternating sitting and standing?
...es ☐ No

...the job require using the feet to operate foot controls?
...es ☒ No If yes, on what type of equipment? Except for driving auto

...portant is good vision in the job?
...cessary for reading or drafting technical documents

| ...are the major tasks requiring use of one or both hands? | One Hand | Both Hands |
|---|---|---|
| ...les and marketing travel | ☐ | ☒ |
| ...ting and reviewing proposals, technical documents and reports | ☐ | ☒ |
| ...king technical and sales presentations | ☐ | ☒ |
| ...ing computer for communications/analysis | ☐ | ☒ |

...formation about the job as it relates to the disability

...the job be modified to accommodate the disability either temporarily or permanently?
Yes ☒ No If yes, explain

...les, marketing, presentations and image building are essential to this position

...possible to offer the employee assistance in doing the job (through use of technology or personal assistance for example)?
Yes ☒ No If yes, explain
...sistance would be substantial and costly thus significantly eroding effectiveness

...tachments and Signature (Attach a copy of the employee's job description)
...No job description available. Resume attached.
...e of person completing this form
Dexana MacQuarrie

Dexana MacQuarrie
Signature

Vice President Administration
Title

4/6/94
Date

Telephone (619) 259-5045 Fax (619) 259-5046

86a

EXHIBIT 2

[Logo] *UNUM*

UNUM Life Insurance Company of America
Western Regional Benefits
101 North Brand Blvd., Suite 800
Glendale, CA 91203-2622
818-247-4151
800-424-2008
FAX 818-956-2640

April 13, 1994

JOHN E WARD
140 WALNUT AVENUE #3B
SAN DIEGO CA 92103

RE: John E Ward DOB: 04-24-1930
Claim Number: 4V32664433
Policy Number: 310727—001

Dear Mr. Ward:

We have completed our review of your application for benefits under the above policy.

We regret that we are unable to continue processing your application for benefits because it was not submitted within the time frame specified in the contract. Under the policy provisions regarding notice and proof of claim, the policy specifies the time period in which this proof must be submitted.

Based on a disability date of May 5, 1992, your elimination period would have been satisfied August 7, 1992. Your application for benefits was received on April 11, 1994. As this is beyond the time frame indicated in the policy, we regret to advise you that we will not be able to give consideration to your application for benefits and are closing your claim file.

If you have new, additional information to support your request for disability benefits, please send it to me at the above address.

If you do not agree with our decision, you may have it reviewed. Should you desire a review, you must send a written request, within 60 days of your receipt of this notice, to:

UNUM
LTD Quality Review Section
2211 Congress Street
Portland, ME 04122-0360

Please be sure to include your Social Security and policy numbers. Your written request should include your comments and views of the issues, as well as any documentation you wish UNUM to consider. You may also request copies of pertinent documents contained in your file. If UNUM does not receive the written request within 60 days of your receipt of this notice, our claims decision will be final.

You may also contact the California Insurance Department if you wish to have them review your claim. If you wish to contact the Department by telephone, you should ask for the Consumer Communications Bureau at 1-800-927-HELP (1-800-927-4357) or 213-897-8921. If you wish to write to the Insurance Department, your letter should be addressed to:

California Department of Insurance
Claims Service Bureau, 11th Floor
300 South Spring Street
Los Angeles, California 90013

If you have any questions, please contact me at 1-800-424-2008 ext. 662.



Sincerely,

/s/ Shawna Shapero
SHAWNA SHAPERO
Disability Benefit Specialist

SS / ts

cc: Maria Bonney

EXHIBIT 3

SHAFFMAN, ILER, PALKOWITZ & DOFT
Attorneys at Law
110 West "C" Street, Suite 1905
San Diego, California 92101

Area Code 619
Telephone 231-1841
Fax (619) 236-7932

June 6, 1994

*CERTIFIED MAIL—*
*RETURN RECEIPT REQUESTED*

UNUM LTD QUALITY REVIEW SECTION
2211 Conger Street
Portland, ME 04122-0306

Re: Our Client : John E. Ward
Your Insured : John E. Ward
DOB : 04/24/30
Claim No. : 4V32664433
Policy No. : 310727-001

WRITTEN REQUEST FOR REVIEW

TO WHOM IT MAY CONCERN:

I have been retained by Mr. Ward to represent him as the result of your denial of long term disability benefits which was made on April 13, 1994. Please be advised that this letter is intended to be a request for review as defined in Management Analysis Company's Long Term Disability Income Benefits Booklet, page 28.

On May 5, 1992, John E. Ward became totally disabled as the result of diabetic neuropathy affecting both lower



extremities. At the time of his disability, Mr. Ward was the Chief Executive Officer of Management Analysis Corporation (MAC) and had been employed there for nine years. MAC's in-house benefits administrator was aware of Mr. Ward's disability and in fact was helping coordinate his entitlement to ongoing health care benefits during the summer of 1992. Dexana G. MacQuarrie, Vice President in charge of employee benefits, became aware that Mr. Ward's condition was considered permanent on March 30, 1993. (See attached letter dated March 30, 1993 marked as Exhibit 1). Mr. Ward did not become aware that it was necessary to file an application for long term disability benefits until earlier this year. An application was filed on April 11, 1994 and denied by Shawna Shapiro, Disability Benefits Specialist of the Western Regional Benefits Office on April 13, 1994. (See attached Exhibit 2).

ARGUMENT

Mr. Ward contends that actual notice of his disability was provided to the in-house administrator and as a matter of law that notice was imputed to the insurer, UNUM. In *Elfstrom v. New York Life Ins. Co.* (1967) 67 Cal.2d 503 the California Supreme Court considered the issue of whether an employer which is the named insured under a group insurance policy for the benefit of the employees acts as the agent of the employees or the agent of the insurer in performing the functions necessary to administer the insurance provided by the policy. (See attached Exhibit 3). The high court concluded, in a unanimous decision, that under these circumstances, the employer is the agent of the insurer.

The *Elfstrom* court reasoned that in performing administrative duties related to the group insurance benefits, the employer does not act entirely for its own benefit for the benefit of the employees. Rather, both the insurer and the employer enjoy significant benefits as a result of this arrangement. The employer generally obtains reduced pre-

miums as a result of taking on administrative duties, particularly where there is a large number of employees. (*Elfstrom,* p. 511.) Likewise, the insurer realizes a larger volume of sales and markedly reduced costs for administration. (*Id.*, 513.)

The *Elfstrom* court noted that the insurer in that case had provided written instructions to the employer directing it to perform certain administrative functions such as determining employee's eligibility for insurance, providing pertinent information regarding the employees' salary, class of coverage, etc., and completing the certificate of insurance indicating the amount of coverage. As discussed more specifically below, these facts are very similar to those in the instant case.

In holding that the administrator is the agent of the insurer, the *Elfstrom* court found particularly persuasive the fact that the employee generally has no knowledge or control over the employer's actions in handling the policy or its administration. "An agency relationship is based upon consent by one person that another shall act in his behalf and be subject to his control." (*Id.*, p. 513.) Because the insurer directs the performance of the employer's administrative acts, if these duties are not undertaken properly, the insurer is in a position to exercise more constricted control over the employer's conduct. (*Id.*, pp. 513-514.)

Here, as in *Elfstrom*, the insurer, UNUM, required the employer to perform certain administrative tasks. Section VI, subsection D of the Long Term Disability Contract provides as follows:

1. The employer will furnish at regular intervals to the Company:

   a. information relative to employees:

      i. who qualify to become insured;



      ii. whose amounts of insurance change; and/or

      iii. whose insurance terminates.

   b. *Any other information about this policy that may be reasonably required.*

   The employer's records which, in the opinion of the Company, have a bearing on the insurance will be opened for inspection by the Company at any reasonable time.

Subsection F goes on to discuss Notice and Proof of Claim procedures and indicates that written notice of claim must be given to the Company within certain time periods. It does not specify whose responsibility it is to give notice (i.e., the employee or the employer/administrator which is on notice of the claim or potential claim.)

Based on the discussion in *Elfstrom*, the facts here support a finding that the employer/administrator was an agent of the insurer for purposes of imputing its knowledge of an employee disability claim to the insurer. Specifically,

> The employer here was, under its contract with UNUM, required to perform administrative functions with respect to the disability plan which were similar to those required of the employer in *Elfstrom*. In addition, the employer was further required to perform other unidentified functions such as providing "any other information about the policy which may be reasonably required."

Because this company had a substantial number of employees, both the company and the insurer undoubtedly benefitted from the relationship with the insurer obtaining additional business and the company obtaining reduced premiums, a factor which the *Elfstrom* court considered in its analysis of the agency relationship which exists between insurer and employer/administrator.

Also pursuant to the policy, the company's records were open to inspection by the insurer for any purpose which the insurer deemed appropriate, lending further support to the conclusion that the company had an obligation to adequately maintain its employee files for the benefit of the insurer.

Because the employees were apparently never provided with the entire disability insurance contract between the insurer and the employer, but rather received only a pamphlet entitled "Your Long Term Disability Income Benefits" the employees undoubtedly had little or no knowledge of or control over the employer's actions in administering the policy, another factor deemed important by the *Elfstrom* court. Moreover, this pamphlet specifically provides at page 26:

> 2. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.
>
> 3. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

California Law supports a finding that because of the agency relationship which exists between UNUM and MAC, where the plan administrator has actual knowledge of an employee's permanent disability and the employers actively assisting the employee in obtaining and preserving various insurance benefits, the employer's actual knowledge of the employee's potential disability claim should be imputed to the insurer.

Based upon the foregoing it is respectfully requested that UNUM reconsider its denial of beinefits in this matter and provide the LTD benefits Mr. Ward is entitled to.



Dated: 6/6/94

/s/ Brooks L. Iler
BROOKS L. ILER
Attorney fo John E. Ward

cc: Shawna Shapero
Disability Benefit Specialist
UNUM Life Insurance
101 North Brand Blvd., Suite 800
Glendale, CA 91203-2622

[Logo] *UNUM.*

UNUM Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
207-770-2211
800-822-9103
FAX 207-770-6997

July 12, 1994

BROOKS L ILER
110 WEST C STREET, SUITE 1905
SAN DIEGO CA 92101

RE: John E Ward DOB: 04-24-1930
Claim Number: 4V32664433
Policy Number: 310727—001

Dear Mr. Iler:

We have completed our review of Mr. Ward's Long Term Disability claim and conclude that the decision to deny liability due to late filing was correct.

The contract clearly states that "proof of claim must be given to the Company", and specifies the time frame in which this proof must be given. The "Company" being UNUM Life Insurance Company of America. It appears that Mr. Ward's policy constitutes an ERISA plan. Management Analysis Company, Mr. Ward's employer, through the purchase of group insurance to provide disability benefits to its employees, has established an employee welfare benefit plan within the meaning of ERISA. The U.S. Supreme Court in the *Pilot Life* decision established that questions of contract interpretation arising under an ERISA-regulated plan are issues of federal, not state law. Thus, the question of whether your client's employer was UNUM's "agent" for purposes of this matter is a federal law question, not a California state law question. Under



ERISA, the employer has the sole responsibility to provide employees with timely and accurate disclosure of the terms of the plan to its employees. The fact that he may not have been aware of the existence of the policy or of its provisions does not alter the validity of those provisions.

The Agency Provision of the policy, states:

> For all purposes of this policy, the policyholder acts on its own behalf or as agent of the employee. Under no circumstances will the policyholder be deemed the agent of the Company without a written authorization.

The Notice and Proof of Claim provision, states:

Proof

a. Proof of claim must be given to the Company. This must be done no later that 90 days after the end of the elimination period.

b. If it is not possible to give proof within these time limits, it must be given as soon as reasonably possible. But proof of claim may not be given later than one year after the time proof is otherwise required.

Under the express terms of the policy, Mr. Ward needed to submit proof of claim by November 5, 1992, and if, and only if, it was impossible for him to do so by that date, no later than November 5, 1993. His claim was not received until April 11, 1994, beyond the time frame stipulated in the policy. Due to Mr. Ward's delayed application for benefits, we are unable to give consideration to his claim.

We regret that our determination could not be more favorable, but we must abide by the policy provisions.

Sincerely,

/s/ Marie Lamson
MARIE LAMSON
Senior Benefit Analyst

ML / ml

cc: Maria Bonney
Michael Stevens



## STATUTORY PROVISIONS

ERISA § 2(a), (b), 29 U.S.C. §§ 1001(a), (b):

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stabiilty of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated,

employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

ERISA § 3(1), (16), 29 U.S.C. § 1002(1), (16):

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).



(16)(A) The term "administrator" means—

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

(B) The term "plan sponsor" means (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

ERISA § 402(a), 29 U.S.C. § 1002(a), (b):

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(2) For purposes of this subchapter, the term "named fiduciary" means a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly.

(b) Requisite features of plan

Every employee benefit plan shall—

(1) provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of this subchapter,

(2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan (including any procedure described in section 1105(c)(1) of this title),

(3) provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan, and

(4) specify the basis on which payments are made to and from the plan.

ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D):

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;



(C) by diversifying the investments of the plan so as to minimize the risk of large looses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

ERISA § 502(a)(1)(1)(B), 29 U.S.C. § 1132(a)(1)(B):

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

ERISA § 503, 29 U.S.C. § 1133:

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

ERISA § 514(a), (b)(2)(A), (B), (d), 29 U.S.C. § 1144(a), (b)(2)(A), (B), (d):

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, on investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.



(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

29 C.F.R. § 2560.503-1(b),(c),(d):

(a) *Scope and purpose.* (1) This section sets out certain minimum requirements for employee benefit plan procedures pertaining to claims by participants and beneficiaries (claimants) for plan benefits, consideration of such claims, and review of claim denials, hereinafter referred to in the aggegate as "claims procedures." Except as otherwise noted, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Employee Retirement Income Security Act of 1974 (the Act).

(b) *Obligation to establish a reasonable claims procedure.* Every employee benefit plan shall establish and maintain reasonable claims procedures.

(1) A claims procedure will be deemed to be reasonable only if it:

(i) Complies with the provisions of paragraphs (d) through (h) of this section, except to the extent that it is deemed to comply with some or all of such provisions under the authority of paragraph (b)(2) or paragraph (j) of this section.

(ii) Is described in the summary plan description, as required by § 2520.102-3,

(iii) Does not contain any provision, and is not administered in a way, which unduly inhibits or hampers the initiation or processing of plan claims, and

(iv) Provides for informing participants in writing, in a timely fashion, of the time limits set forth in paragraphs (e)(3) and (g)(3) and paragraph (h) of this section.

(2) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees):

(i) Such plan will be deemed to comply with the provisions of paragraphs (d) through (h) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference.

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) Agrievance and arbitration procedure to which denied claims are subject.

(ii) Such plan wll be deemed to comply with the provisions of paragraphs (g) and (h) of this section (but will not be deemed to comply with paragraphs (d) through (f)) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which denied claims are subject (but not provisions concerning the final and initial disposition of benefit claims).

(c) *Claims procedure for an insured welfare or pension plan.* (1) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for filing of a claim for benefits with and notice of decision by such company, service or organization.



(2) See paragraph (g) regarding review and final decision on denied claims by insurance companies, insurance services and similar organizations.

(d) *Filing of a claim for benefits.* For purposes of this section, a claim is a request for a plan benefit by a participant or beneficiary. A claim is filed when the requirements of a reasonable claim filing procedure of a plan have been met. If a reasonable procedure for filing claims has not been established by the plan, a claim shall be deemed filed when a written or oral communication is made by the claimant or the claimant's authorized representative which is reasonably calculated to bring the claim to the attention of:

(1) In the case of a single employer plan, either the organizational unit which has customarily handled employee benefits matters of the employer, or any officer of the employer.

(2) In the case of a plan to which more than one unaffiliated employer contributes, or which is established or maintained by an employee organization, either the joint board, association, committee or other similar group (or any member of any such group) administering the plan, or the person or organizational unit to which claims for benefits under the plan customarily have been referred.

(3) In the case of a plan the benefits of which are provided or administered by an insurance company, insurance service, or other similar organization, which is subject to regulation under the insurance laws of one or more States, the person or organizational unit which handles claims for benefits under the plan or any officer of the insurance company, insurance service, or similar organization.

(g) *Review procedure.* (1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary

or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized representative may:

(i) Request a review upon written application to the plan;

(ii) Review pertinent documents; and

(iii) Submit issues and comments in writing.

(2) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company, service or organization. In such case, that company, service, or organization shall be the "appropriate named fiduciary".